			1 - For Registrar	State of Marylar		artment of H			ene g. No. 2005	14001
			Decedent's Name (First, Middle, Last)					2. Date of Death	1	3. Time of Death
	Physicia /Medic		Martin Edward Vae	th				April 5	, 2005 Year	10:10 P <sup>M</sup>
<b>&gt;</b>	Examin		4a. Facility Name (If not institution, give st.	reet and number)		4b. City, Town, or	Location of Death		4c. County of Dea	
1			2701 Yeoman's Lante			Annapo			Anne Arı	ındel
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs.		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year) 9. Bir	thplace (State or Foreign buntry)
	Director		Usual Residence of Decedent	M 2UF   42	Yrs.			5-11-196	52 Was	hington, DC
	and and		10a. State 10b. County	10c. Ci	ty, Town or Lo	cation				10d. Inside City Limits
	f sho	ō	Maryland Worcester		Dowl					1 ☐ Yes 2X No
	the 28a	Directo	10e. Street and Number		Berli	10f. Zip Code		10	g. Citizen of What Co	ountry?
	3e or	ā	11649 Maid at Arms	Lane		2181	1		USA	
	death with the Maryland ms 23e or 28a-f show reals by pullibed at	Funeral		2. Was Decedent Ever in U	J.S. 13. V	Was Decedent of H f Yes, specify Cuba		ecify Yes or No-	14. Race - Ame	ancan Indian,
٥	after or Ital		1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 X No	1			Rican, etc.)	Black, Whi	
2-003p	72 hours after natural', or Ita	l by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1□Yes 2XINo	Specify:		Specify: Wh	nite
	72 h natu	Completed	15. Decedent's Educa (Specify only highest grade	ation completed)	(Give	dent's Usual Occupa	during most of work	sing	6b. Kind of Business	/Industry
7	within lene. than "	Idm	Elementary/Secondary (0-12)	College (1-4or 5+)	life. I	DO NOT use retired	)		G 3.6	
7	be filed within 72 hours after death with the Marylan at Hygiene. All Hygiene. All Hygiene. Avant, Ital Medical Exercitive rotal be publised at avant, Ital Medical Exercitive rotal be publised at		17. Father's Name (First, Middle, Last)	3 years	Sale	esman	40.44.0.1.11	(5) A 14: 14: 1	Golf	
yland	t be find the of ed of avail	Be	Emmett Jerome V	Vaeth Sr				e (First, Middle, M		
	2 should be and Mental is marked of raumatic ave	To		<u> </u>	405 44500		<del>_</del>	Patrici		T. 0.11
2	nd 2 sl lith and 27 is r r traur		19a. Informant's Name/Relationship (Type	•					City or Town, State,	T CASTRONIA
	is 1 and of Health itam 27 other ti		Emmett J. Vaeth, St. 20a. Method of Disposition		2/01 Place of Dispo	Yeoman's	Lantern	Ct., Ann	apolis, MI	21401 Town State
more,	Pages nent of int: If its		1 ☐ Burial 2 💆 Cremation 3 ☐ Re	moval from State	cemetery, crer	natory or other place ematory	(4-7-i	_	•	
	- 보 <b>라</b>		*4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service Licensee						Edgewater, Kalas Fune	
galt	perm Depa Impo any ic		Valoret 1.Che	1-					dgewater,	
1	- A - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1		23a. Part1. Enter the disease, or complic	ations that caused the dea					- <del>-</del>	Approximate
	Dhucinion		shock, or heart failure. List only one Immediate Cause (Final	cause on each line.	0 :	0	•			Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	Metastat  Due to (or as a conse		ion Con	Cen			lyear_
	Examiner			500 10 (0) 43 4 001136	4001100 01).					
		Jer	Sequentially list conditions, in any, reading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (cr as a conse	Juanua oli).					
	cuted nd ransi	Examiner	that initiated events							
Ď,	be executed ician and burial-transit	EX	resulting in death) Last	Due to (or as a conse	quence of):					
9/90	ate hys	dical	d.							
õ	certificate nding phys	Mec	IF FEMALE:							
Ž Q	death co	lan/	23b. Was decedent pregnant in the past 12 months?	c. If yes, outcome of pregn 1 Live birth 2 Fet	al death 3	Ectopic pregnancy			23d. Date of de Month	livery Day Year
	the a	hystclan/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4⊟Pregnant at time of 9⊟Unknown	death 5	Other (specify)				July 1 da.
7.	that the side by detact	<u>a</u>	Part II. Other significant conditions cont	ributing to death but not re-	sulting in the u	ndertving cause giv	en in Part I	23e Did tob	acco use contribute t	o the cause of death?
a S	w requires that the death certific been signed by the attending p should be detached for use as	d by	3			neonying oddoo giv	orrain arra	1 □ Ye		robably 4 □Unknown
5	v requ	Completed						- NE		
ě	The law ate has boage 2 sh	mp						24a. Was ar autops perform	/ prior to	utopsy findings available completion of cause of
	n: Th	e Co	OF Was assessed to a disch					1 ☐ Yes 2	No 1 □ Ye	2 □ No
<b>=</b>	Physician: rthis certific ral director,	o Be	25. Was case referred to medical examiner?	ospital:	ER/Outpatier	oth		th (Check only one		Parent's
0	y Phy er this eral d	$\vdash$	27. Manner of Death	28a. Date of Injury	28b. Time of	IL 3 DOA	4   Isursing H	ome 5 Reside		Home
SION	nding ath. r: Aft	atlo	Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury		k? Yes 2 ⊡No			
<u> </u>	Atta ecto by th	ertification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At I	lome, farm, str	eet, factory, office		28f. Location (Str	eet and Number or F	ural Route Number,
5	tal or	Cert	4 - Horricide	building, etc. (Speci	ny)			City or Town	, Sia(e)	
	To the Hospital or Attanding Physician: The law within 24 bours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.		29a. Certifier Certifying Physic (Check only 2 Medical Examine	icien: To the best of my kn er: On the basis of examin	owledge, deatl	n occurred at the tin	ne, date and place	and due to the ca	use(s) and manner a	s stated.
	tha P hin 24 the F	<b>ledical</b>	one)	and manner stated.	anon and/or in					
	To To Con	Σ	29b. Signature and title of certifier			29c. Licens		29	d. Date signed (Mon	th, Day, Year)
			va only	DMO		D306	217		7/1105	
			Name and address of person who con	npleted cause of death (Ite	m 23a) (Type,	Print)	1 5	Bart A	d 21811	
	Sta	to	31. Date filed (Month, Day, Year)	Registrar's Sign	ature	421/0 30	moe 1	DESCIN IN	CA 01011	
	Registr	31	APR 0 8 2009		A A	and a				

.34	8		1- State Amend Item 1 per me G844 6-	/ Depa 24-05 <i>Cer</i>	irtment of H	lealth and <mark>I</mark> Death	Mental Hy	giene Reg. No.	2005	11.000
	Physici /Medic		1. Decedent's Name (First, Middle, Last) Jon Kevin Will JOHN K. WILLIAM	iams S			2. Date of De		O5 Year	3. Time of Death 5:50 P M
>	Examin		4a. Facility Name (If not institution, give street and number) 9983 Good Luck Road		4b. City, Town, or Lanham	r Location of Death	1		ounty of Death Ce Geor	ge¹s
	Funeral Director		5. Social Security Number 212-94-4681 6. Sex 17. Age (In yrs. last 25	v birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Date Aug • 2	17 , 19	79 Ma	place (State or Foreign
	a-f show	ctor	Usual Residence of Decedent  10a. State 10b. County 10c. City, T  MD Prince Geo	own or Loc	cation Lanha	am			1	0d. Inside City Limits  Y☐ Yes 2☐ No
	th with the 23e or 28	ai Director	10e. Street and Number 9983 Good Luck Road, #T-1		10f. Zip Code 20	706		-	on of What Cour	ntry?
036	72 hours after death with the Maryland natural', or tems 23e or 28e f show acal Examination must be modified at	by Funerai	11. Marital Status  ↑ Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1  Yes 2 No If Yes, Give Year or Dates:	If	Vas Decedent of H Yes, specify Cuba	ispanic Origin? (Si an, Mexican, Puert Specify:	pecify Yes or No o Rican, etc.)		Black, White,	
21215-0036	within ane. then "	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  9th	(Give k life. D	ent's Usual Occup kind of work done o DO NOT use retired Detailer	during most of wor d)	king		of Business/Ind	-
Maryland 2	uld be filed Aental Hygir rked other tic event, ii	To Be C	17. Father's Name (First, Middle, Last)  John T. Williams			18. Mother's Nan		, Maiden S		
	es 1 and 2 should be of Health and Mental f Item 27 is marked r other traumatic ev		19a. Informant's Name/Relationship (Type, Print) Peggy L. Washington (Mothe	19b. Mailing	g Address (Street of 9983 GC	and Number or Ru ood Lucl	ral Route Numb	er, City or 1 #Tl,	Town, State, Zip Lanhar	n, MD
altimore,	permit. Pages 1: Department of He Important: If Item eny injury or oth		20a. Method of Disposition  1 \ Burial 2 \ Cremation 3 \ Removal from State  4 \ Donation 5 \ Other (Specify)	acery, crem	sition (Name of patory or other place Heaven	Cem 4/1	Date .1/05		ation-City or To	own, State
Balt	permit. Depart Import eny inj		21. Signatur of Funeral Service Licenses	1 24	6 N. Wa	ash. St.	, Roc	<vil1< td=""><td></td><td>ome, P.A. 20850</td></vil1<>		ome, P.A. 20850
	Physician /Medical		23a. Part1. Enter the disease, or complications that caused the death, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)	gun	shot wi	,	or respiratory a	rrest,		Approximate Interval Between Onset and Death
68760,	ficate be executed by physicien and ts the burial-transit	edicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequent or consequent o	nce of):						
P.O. Box 68	death certi e attending id for use a	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal de 4 □ Pregnant at time of death	ath 3 🗆	Ectopic pregnancy Other (specify)	,		23	d. Date of delive	ery Day Year
	The law requires that the set has been signed by the bage 2 should be detache	by	Part II. Other significant conditions contributing to death but not resulting	ig in the un	derlying cause gre	en in Part I.	23e. Did	V		ne cause of death?
Division of Vital Records,	The la	Completed							prior to cor death?	psy findings available mpletion of cause of
<del>=</del>	s certif	To Be	25. Was case referred to medicat examiner?  1 XYes 2 No  Hospital: 1 Inpatient 2 ER	/Outpatient	2CI DOA Oth	26. Place of Dea				at goons
l of	g Ph) ter this		27. Manner of Death 28a. Date of Injury 28	b. Time of	28c. Injun Worl	4 🗀 Nursing n	28d. Describe			at scene
sior	endin sath. or: Aft he fur	atlo	2 Accident investigation 4-3-05 5	Injury	M 1	Yes 2 No	subjec	t win	s shot	
Divis	To the Hospitel or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificete his completely filled in by the funeral director, page	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home building, etc. (Specify)	siden			28f. Location ( City or To	wn, State)	Number or Rura 9983 Geo	A Route Number
	the Hosp hin 24 hou the Fune mpletely fil	Medical	29a. Certifier  (Check only one)  1□ Certifying Physicien: To the best of my knowle 2  Medicel Examiner: On the basis of examination and manner stated.	dge, death and/or inve	estigation, in my o	pinion, death occu	, and due to the rred at the time,	date and p	lace, and due to	the cause(s)
	To with	_	29b. Signature and title of certifier  Mills (Mills) (Mills)		OCI				April 4	
			30. Name and address of person who completed cause of death (Item 23	ia) (Type, P	111 Per	ກກ Street	Balti	more,	Maryla	nd 21201
	Sta Registr		31. Date filed (Month, Day, Year) APR 11 2005  32 Aegistrar's Signature	don.	who					

			1 - For State Registrar		State of N	Marylar	-			lealth a		lental Hy	giene	0.00	15	1400:	3
ı	Physici	an	1. Decedent's Name (First, Mi Kathryn War		) Slater							2. Date of Do	eath Day 5	, ,	2005	3. Time of Death	
1	/Medic	al	4a. Facility Name (If not institu			ar)		4h City	Town or	Location of	of Death	April		County		8:42 P	м
	Examin	er	Shady Grove A					1	kvi1		JI Dealii				gomer	v	
	Funeral		5. Social Security Number	6. Se	x 7.		last birthday)		r 1 Year	If Under Hours	24 Hrs. Min.	8. Date of Bi (Month, D				lace (State or Foreitry)	ign
	Director		579-48-7128 Usual Residence of Decedent	11	⊒м 2 <b>[Х</b> [F	71	Yrs.	IVIOTIIIIS	Days	riours	IVIII I.	July 9	9,193	3 V	Vashi	ngton D.	σ.
	ryland how		10a. State 10b. Cou	•			ty, Town or Lo								1	0d. Inside City Limi	ts
	Sa-f s	ctor	Md. Mon	tgome	ery	Mor	ntgomer	y Vi	llage	е						1 ☐ Yes 2 💢 N	10
	with th	Dire	10e. Street and Number	. D1.				10f. Zi	p Code	20886			_		Vhat Cour	*	
	eath	erai	9403 Chattero	y Fla	12. Was Decede	nt Ever in U	S 13	Was Dece			gin? (Spe	cify Ves or N			Stat - Americ		
90	permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: if Item 27 is marked other then "neturel" or Items 23a or 28a-f show many nury goother treumatic event, Ite Madical Examinant must be natified at annex.	by Funeral Director	1 Never Married 2 N		Armed Force 1 Tes 2 Tes	s?		If Yes, spo		n, Mexicar		acify Yes or N Rican, etc.)			k, White,	etc.	
21215-0036	hours turel',	q pe	3 Widowed 4 □ Divor		Year or Dates	S: 							105 10		******		
2	in 72 in 72	Completed	15. Dece (Specify only high	hest grad	le completed)		16a. Dece (Give life.	kind of w DO NOT	ial Occupi ork done d ise retired	ation during mos f)	t of worki	ing	16b. K	ind of Bu	siness/Ind	dustry	
212	d with giene. ir ther	Шо	Elementary/Secondary (0-1	2)	College (1-4d	or 5+)	Admir			•	ista	nt	Ins	surar	nce		
밀	al Hyg	Be C	17. Father's Name (First, Mide	lle, Last)						18. Mothe	er's Name	(First, Middle	, Maiden	Sumam	9)		
<u>X</u> a	Menta Menta arked atlc e	To	Howard Selle	rs						Suz	anne	Baer					
Maryland	2 short and reum		19a. Informant's Name/Relati					-				al Route Numb				Code)	
9	1 end Healtl em 27		Tracey Warner 20a. Method of Disposition	(Dai	ighter)	20b. i						ward, (			City or To	wn State	
no.	ages int of		1 ☐ Burial 2 🏋 Cremation 4 ☐ Donation 5 ☐ Othe				Place of Disponentery, creation of the contract of the contrac				Apri						
Baltimore,	artme crten njur		21. Signature of Funeral Serv			Tie	_			ss of Facili	2005				ria,	va.	-
ä	Per		· Cuetas E	1	24						ре	Vol Fui Dr. Ga				d. 20877	
			23a. Part1. Enter the disease shock, or heart failure.	or comp	lications that caus	ed the dear	th. Do not ent	ter the mo	de of dyin	g, such as	cardiac o	or respiratory	arrest,			Approximate Interval Between	
	Physician	4	Immediate Cause (Final disease or condition resulting in death)	_	a. Concest	tive I	leart E	ailu	re						1	Onset and Death 4 Days	
	/Medical Examiner		rooming in doding	1	Due to (or a					C. Trans					ij		
		er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		Acute Re	espira as a consec		)1str	ess :	Syndr	ome		-		1	4 Days	-
	cuted nd ransit	Examiner	that initiated events	1	C.												
Ö,	The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	i Exa	resulting in death) Last		Due to (or a	as a consec	quence of):						-				
8760,	cate b	dicai			d		<del></del>										
9 X	leath certifica attending ph ifor use as th	Physician/Med	IF FEMALE:		23c. If yes, outcon	ne of pream	ancv							00d Day	4 deli-		
Вох	atten 1 for u	cian	23b. Was decedent pregnant in the past 12 months?		1 ☐Live birth 4 ☐ Pregnant	2 Feta	aldeath 3	□Ectopic p □ Other (s						Mor	e of delive nth	ny Day Year	
P.O.	that the de led by the a detached	hysi	1 ☐ Yes 2 🔯 No 9 ☐ Unknown		9 Unknown			,	,,,								
	res tha igned be det	by P	Part II. Other significant con-	litions co	ntributing to death	but not res	sulting in the u	ınderlying	cause give	en in Part I		23e. Did	tobacco	use contr	ribute to th	e cause of death?	
ord	w requir been si should							_				1 🗆	Yes 2	<b>X</b> No	3 Prob	ably 4 ∐Unknov	٧n
Sec.	elaw hasb je 2 st	Completed										24a. Wa auto	DOSV	l p	prior ta cai	psy findings availat npletion of cause o	ole if
a												1 ☐ Yes	ormed? 2X No		leath?	2 🗆 No	
₹	<b>hysicien</b> : The la his certificate ha I director, page 2	o Be	25. Was case referred to med examiner? 1 ☐ Yes 2 ☑ No	-	Hospital: 1 ∏ Inpa	ationt 2	ER/Outpatier	nt 3 🗆 D	OA Othi			n <i>(Check only</i> me 5 ☐ Res		-			
ı of	Attending Physicien: or death. ector: After this certificaby the funeral director.	n: To	27. Manner of Death		28a. Date of Ir (Month, I		28b. Time o		28c. Injun Worl			28d. Describe				/)	_
jo	tending Ph leath. tor: After th the funeral	atlo		stigation	(MORTI, I	Jay 18ai)	Injury	М		Yes 2 ☐	No						
Division of Vital Records,	i Citt	Certification:		ald not be armined	28e. Place of building,	Injury - At h etc. <i>(Speci</i>	ome, farm, str fy)	reet, facto	ry, office			28f. Location City or To	(Street ar own, State	nd Numbe e)	er or Rura	l Route Number,	
	To the Hospitel or At within 24 hours after or To the Funerel Direct completely filled in by	a Ce	29a. Certifier 1 📆 Certi	lying Phy	sicien: To the be	st of my kno	owledge, deat	h occurred	d at the tin	ne date ar	nd place.	and due to the	a causals	and ma	nner as si	ated	
	n 24 h	edical	(Check only 2 Medi	al Exam	iner: On the basis and manner	of examina	ation and/or in	vestigatio	n, in my o	pinion, dea	th occurr	ed at the time	, date an	d place, a	and due to	the cause(s)	
	To the within To the comp	Me	29b. Signature and title of cer	ifier					c. Licenso				29d. Da	te signed	(Month,	Day, Year)	
	10		1110						MA402	26489	00		Apri	117,	, 200	5	
	( -		30. Name and address of pers						_	1 110	01 -						
	Sta	to.	Dr. Thomas Od 31. Date filed (Month, Day, Yo	ar)						ad #2	UI R	ockvil	Le, N	1d. 2	20850		
	Registr			1 2	005	was	B A	MALL.									

Richard B. Wachenfeld 05-2439 AKG

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Usual Residence of Decedent 10a. State 10b. County MD Queen Anne's Chestertown  10f. Zip Code 21620  11. Marital Status 1   Never Married 2   Married 3   Ziwas Decedent Ever in U.S. 1   Never Married 2   Married 3   Ziwas Decedent Ever in U.S. 1   Never Married 3   Ziwas Decedent of Hispanic Origin? (Specify Yes of Married 2   Married 3   Ziwas Decedent of Hispanic Origin? (Specify Yes of Married 3   Ziwas Decedent of Hispanic Origin? (Specify Yes of Married 3   Ziwas Decedent of Hispanic Origin? (Specify Yes of Married 3   Ziwas Decedent of Hispanic Origin? (Specify Yes of Married 3   Ziwas Decedent of Hispanic Origin? (Specify Yes of Married 2   Married 3   Ziwas Decedent of Hispanic Origin? (Specify Yes of Married 3   Ziwas Decedent of Hispanic Origin? (Specify Yes of Married 2   Xiwas Decedent of Hispanic Origin? (Specify Yes of Married 2   Xiwas Decedent of Hispanic Origin? (Specify Yes of Married 2   Xiwas Decedent of Hispanic Origin? (Specify Yes of Married 2   Xiwas Decedent of Hispanic Origin? (Specify Yes of Married 2   Xiwas Decedent of Hispanic Origin? (Specify Yes of Married 2   Xiwas Decedent of Hispanic Origin? (Specify Yes of Married 2   Xiwas Decedent Seducation 1   Never Married 2   Married 3   Xiwas Decedent Seducation 1   Never Married 2   Xiwas Decedent Seducation 1   Yes of Ziwas Septicity 1   Yes of Ziwas   Xiwas Decedent of Hispanic Origin? (Specify Yes of Yes of Decedent Seducation   Xiwas Decedent of Hispanic Origin? (Specify Yes of Yes of Decedent Seducation   Xiwas Decedent of Hispanic Origin? (Specify Yes of Yes of Decedent Seducation   Xiwas Decedent of Hispanic Origin? (Specify Yes of Yes of Decedent Seducation   Xiwas Decedent of Hispanic Origin? (Specify Yes of Yes of Decedent Seducation   Xiwas Decedent of Hispanic Origin? (Specify Yes of Yes of Decedent Seducation   Xiwas Decedent of Hispanic Origin? (Specify Yes of Yes of Decedent Seducation   Xiwas Decedent of Hispanic Origin? (Specify Yes of Yes of Decedent Seducation   Xiwas Decedent of Hispanic Origin? (Specify Yes of Dec	1 7, 2005   10:05 A M
Medical Examiner   April 1   Apolity Name (It not institution, give street and number)   Apolity Name (It not institution, give street and number)   Apolity Name (It not institution, give street and number)   Apolity Name (It not institution, give street and number)   Apolity Name (It not institution, give street and number)   Apolity Name (It not institution, give street and number)   Apolity Name (It not institution, give street and number)   Apolity Name (It not institution, give street and number)   Apolity Name (It not institution, give street and number)   Apolity Name (It not institution, give street and number)   Apolity Name (It not institution, give street and number)   Apolity Name (It not institution, give street and number)   Apolity Name (It not institution, give street and number)   Apolity Name (It not institution, give street and number)   Apolity Name (It not institution, give street and number)   Apolity Name (It not institution, give street and number)   Apolity Name (It not institution, give street and number)   Apolity Name (It not institution)   Apolity Name (It not in	4c. County of Death  Queen Anne's 9. Birthplace (State or Foreign No. 10d. Inside City Limits 1
The Hickory Lane    Social Security Number   6.5 ex   18	Oueen Anne's  9. Birthplace (State or Foreign ND  10d. Inside City Limits 1
S. Social Security Number   158-20-6507   158 most	9. Birthplace (State or Foreign ND 23, 1926 ND 10d. Inside City Limits 1 Yes 2\(\frac{1}{2}\) No  10g. Citizen of What Country?  USA  14. Race - American Indian, Black, White, etc.  Specify: White  16b. Kind of Business/Industry  Legal  iddle, Maiden Sumame)  10mber, City or Town, State, Zip Code)  Chester, PA 19380  20c. Location - City or Town, State  00b Stevensville, MD  ewnam Funeral Home, P.A.
158-20-6507   12   15   15   15   15   15   15   15	10g. Citizen of What Country?  USA  11d. Inside City Limits 1
10a. State   10b. County   10c. City, Town or Location   10c. City, City, Vis.	1 Tyes 2 No  10g. Citizen of What Country?  USA  or No- 14. Race - American Indian, Black, White, etc. Specify: White  16b. Kind of Business/Industry  Legal iddle, Maiden Sumame)  Legal  compared to the ster, PA 19380  20c. Location - City or Town, State  20c. Stevensville, MD  ewnam Funeral Home, P.A. own, Maryland 21620
The property of the property o	1 Tyes 2 No  10g. Citizen of What Country?  USA  or No- 14. Race - American Indian, Black, White, etc. Specify: White  16b. Kind of Business/Industry  Legal iddle, Maiden Sumame)  Legal  compared to the ster, PA 19380  20c. Location - City or Town, State  20c. Stevensville, MD  ewnam Funeral Home, P.A. own, Maryland 21620
The property of the property o	10g. Citizen of What Country?  USA  14. Race - American Indian, Black, White, etc. Specify: White  16b. Kind of Business/Industry  Legal  iddle, Maiden Sumame)  Chester, PA 19380  20c. Location - City or Town, State  20c. Stevensville, MD  ewnam Funeral Home, P.A.  own, Maryland 21620
The property of the property o	14. Race - American Indian, Black, White, etc. Specify: White  16b. Kind of Business/Industry  Legal iddle, Maiden Sumame)  Sumber, City or Town, State, Zip Code) Chester, PA 19380  20c. Location - City or Town, State  005 Stevensville, MD  ewnam Funeral Home, P.A. own, Maryland 21620
The property of the property o	Black, White, etc.  Specify: White  16b. Kind of Business/Industry  Legal  iddle, Maiden Sumame)  Sumber, City or Town, State, Zip Code)  Chester, PA 19380  20c. Location - City or Town, State  005 Stevensville, MD  ewnam Funeral Home, P.A.  own, Maryland 21620
The property of the property o	Legal  Jumber, City or Town, State, Zip Code) Chester, PA 19380  20c. Location - City or Town, State  OD5 Stevensville, MD  ewnam Funeral Home, P.A. cwn, Maryland 21620
19a. Informant's Name/Relationship (Type, Print)  19a. Informant's Name/Relationship (Type, Print)  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Name Name Name Name Name Name Name Nam	Jumber, City or Town, State, Zip Code) Chester, PA 19380  20c. Location - City or Town, State 005 Stevensville, MD ewnam Funeral Home, P.A.
19a. Informant's Name/Relationship (Type, Print)  19a. Informant's Name/Relationship (Type, Print)  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Name Name Name Name Name Name Name Nam	Jumber, City or Town, State, Zip Code) Chester, PA 19380  20c. Location - City or Town, State 005 Stevensville, MD ewnam Funeral Home, P.A.
19a. Informant's Name/Relationship (Type, Print)  19a. Informant's Name/Relationship (Type, Print)  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Name Name Name Name Name Name Name Nam	Chester, PA 19380  20c. Location - City or Town, State  005 Stevensville, MD  ewnam Funeral Home, P.A. bwn, Maryland 21620
20a. Method of Disposition    Date	Chester, PA 19380  20c. Location - City or Town, State  005 Stevensville, MD  ewnam Funeral Home, P.A. bwn, Maryland 21620
1   Burial 2   Cremation 3   Removal from State	OO5 Stevensville, MD ewnam Funeral Home, P.A. own, Maryland 21620
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respirate shock, or heart failure. List only one cause on each line.    Immediate Cause (Final disease or condition resulting in death)	
23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respirate shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that infliated events resulting in death) Last  Due to (or as a consequence of):	
disease or condition resulting in death)    Medical Examiner	Interval Between
Examiner  Sequentially list conditions, if any, leading to immediate cause. Clause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  C. Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):	Onset and Death
Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):	
that initiated events resulting in death) Last Due to (or as a consequence of):	
physicie s the burner of care be selected to the physicie s the pure of care be selected to the physicie s the pure of care be selected to the physicie s the pure of care be selected to the physicie s the pure of care be selected to the physicie s the pure of care be selected to the physicie s the pure of care be selected to the physicie s the pure of care be selected to the physicie s the pure of care be selected to the physicie s the pure of care be selected to the physicie s the pure of care be selected to the physicie s the pure of care be selected to the physicie s the pure of care be selected to the physicie s the pure of care be selected to the physicie s the pure of care be selected to the physicie s the pure of care be selected to the physicie s the pure of care be selected to the physicie s the pure of care be selected to the physicie s the pure of care be selected to the physicie s	
di si più cia di	
Y O O O O O O O O O O O O O O O O O O O	
23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Letopic pregnancy in the past 12 months? 4 Pregnant at time of death 5 Other (specify)	
O of the significant conditions contributing to death but set regulting in the underlying square in Rest I.	23d. Date of delivery  Month Day Year
C Family and the underlying cause given in Part I. 23e.	Did tobacco use contribute to the cause of death?
Vital Records  See Table 1	1 Yes 2 No 3 Probably 4 Unknown
The law requirements to the la	Was an 24b. Were autopsy findings available autopsy
	performed? death? (es 2 ☐ No 1 ☐ Yes 2 ☐ No
Table 1	
2 2 10 1 Impatient 2 2 2 Voltagation 3 DOA 4 Nulsing Home 3	Residence 6 Other (Specify) at scene pribe how injury occurred
25. Was case referred to medical examiner?  15. Was case referred to medical examiner?  16. Place of Death (Check of Death of	ECT SHOT SELF
Company   Comp	ion_(Street and Number or Rural Route Number,
27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 286. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 27. Manner of Death 286. Injury at Nowk? 5 Pending investigation 6 Could not be determined 286. Injury at Nowk? 5 NOT 286. Place of Injury - At home, farm, street, factory, office 286. Injury at Nowk? 5 NOT 286. Place of Injury - At home, farm, street, factory, office 286. Injury at Nowk? 5 NOT 286. Place of Injury - At home, farm, street, factory, office 287. Locat	WORY LANE, LHESTEROWN, HD
29a. Certifier  (Check only)  29a. Certifier  (Check only)  29a. Certifier  (Check only)  20a. Certifier  (Check only)  (Check only)	o the cause(s) and manner as stated. time, date and place, and due to the cause(s)
one) and manner stated.  29b. Signature and title of certifier  OCME	29d. Date signed (Month, Day, Year) April 8, 2005
100000	timore, Maryland 21201
State Registrar APR 1 1 2005 32. Restrar's Signature	

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) April **Physician** 10 2005 Bernadette C. Windsor 1:00 Ам /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 3906 Hawthorn Road Ellicott City Howard If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. July 18, 1921 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🖸 F 215 16 7386 83 Maryland Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits Item 27 is marked other than "natural", or Items 23a or 28a-f show other treumstic event, the Medical Examenar must be notified at 1 ☐ Yes 2 No Director Ellicott City Howard 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 3906 Hawthorn Road 21042 United States Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours effer nent of Health and Mental Hygiene. int: If Item 27 is marked other than "natural", or ite 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify þ 3 ₩idowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Industrial Supply Co. President 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Ida Mae Davis William H. Clark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3906 Hawthorn Road Ellicott City, D 21042 Roger M. Windsor/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages Department of I Important: If it any injury or o 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Meadowridge Cemetery 4-14-2005 | Elkridge, MD 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. 21. Signature of Funeral Service Licensee M01044 4112 Old Columbia Pike Ellicott City, MD 21043 m Collins 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) **Physician** years /Medical Due to (or as a consequence of Examiner Arteriosclarosi Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Dav 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2√ No 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ single kidney of prephractory 2 No 3 Probably 4 Unknown Completed been: 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1☐ Yes 2☐No 1 Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 EP/Outpatient 3 DOA Other: 4 \( \triangle \) Nursing Home \( 5 \) Residence \( 6 \) Other (Specify) ို 1 ☐ Yes \_ 2 🔀 No this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 XNatural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident hours after death 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 0-53636 110 April 11, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ILEVIN CAPLSON lopes charter Drive Columbia 141 31. Date filed (Month, Day Year) 32. Registrar's Signature State Registrar Assett &

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For	State of Marylar	nd / Department of H	lealth and N	lental Hygien	3000	11000
			1 - State Registrar		Certificate of	Death	Reg. No	2005	14006
	Physici	an	Decedent's Name (First, Middle, Last)				2. Date of Death Month Da		3. Time of Death
	/Medic	al	David Lee Watkin		4h City Town	r Location of Death	April 4	. County of Dee	0 0 ""
*	Examin	er	4a. Facility Name (If not institution, give st	/	1 11:	0 1	1	altimor	
	Funeral		5. Social Security Number 6. Sex	ins Hospita 7. Age (In yrs.		If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year)		thplace (State or Foreign
	Director		213-71-6362	M 2□F	Yrs. 6 13	Hours Mai.	September 21.		ryland
	and		Usual Residence of Decedent  10a. State 10b. County	10c. Ci	ty, Town or Location				10d. Inside City Limits
	Maryl	tor	Marvland Frederic	k Fred	derick				1 ☐ Yes 🏋 No
	or death with the Marylan terna 23a or 28a-f ahow or must be notified at	Director	10e. Street and Number	1110	10f. Zip Code		10g. Ci	tizen of What Co	ountry?
	ath wi			Road	21702			ited St	
	itema itema	Funeral	11. Marital Status 13  XXNever Married 2 ☐ Married	2. Was Decedent Ever in U Armed Forces?	I.S. 13. Was Decedent of H If Yes, specify Cuba	lispanic Origin? (Sp an, Mexican, Puerto	pecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit	
936	ursaf	by	3 Widowed 4 Divorced	1 □Yes 21XNo if Yes, Give Year or Dates:	1 ☐ Yes XX No	Specify:		Specify: W	hite
Maryland 21215-0036	filed within 72 hours after death with the Maryland Hygiene. Ither than "natural", or tema 23a or 28a-f ahow Int. I've Medical Examirae must be inclified at	Completed	15. Decedent's Educi (Specify only highest grade	ation completed)	16a. Decedent's Usual Occup (Give kind of work done	during most of worl		(ind of Business	/Industry
121	within	ldmo	Elementary/Secondary (0-12)	College (1-4or 5+)	NI/A	d)	N/	٨	
Q 2	Hygie Other ant, II	e Co	17. Father's Name (First, Middle, Last)	<del> </del>	N/A	18. Mother's Nam	ne (First, Middle, Maider		
<u>lan</u>	should be ind Mental I	To Be	Unknown			Traci Wa	atkins		
lary	2 short		19a. Informant's Name/Relationship (Typ	e, Print)	19b. Mailing Address (Street			or Town, State,	Zip Code)
	l and fealth im 27 ther tr		Traci Watkins/ Mot		5748 Shooksto			MD 21	702
more,	permit. Pages I and 2 should be filed within 72 hours afte Department of Health and Mental Hygiens. Important: If item 27 is marked other than "natural, or it important: If item 27 is marked other than "natural, or it is in item in any injury or other traumatic avent, the Medical Exaction any injury or other traumatic avent, the Medical Exaction any injury.		1 XX urial 2 ☐ Cremation 3 ☐ Re	moval from State	cemetery, crematory or other place	ce)	200.2		
altin	nit. P partme cortan injuri		*4 ☐Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service License		. Olivet Cemetery 22. Name and Addre		9,2005 Fre		
ñ	Depa impo any i		* Kichel O	~	1621 Oposs		ike/Frederi		
			23a. Part 1 Enter the disease or complice shock, or heart failure. List only one	ations that caused the dea				,-	Approximate Interval Between Onset and Death
	Physician		Immediate Čause (Final disease or condition resulting in death)	Gastrointes	hnal hemorr	hage			3 weeks
*	/Medical Examiner		1	Due to (or as a consec		NCB			1 manth
-1		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consec		us C			1 Month
	scuted ind transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last		wel syndro	me			4 months
760,	ate be executed hysicien and he burial-transit	cal Ex	resulting an deathy cast	Due to (or as a consec	ng enterocol	litis			Comonths
687	ficate g phys		d.	1066101121	ng childroto	U 113			Q Welling
Вох	leath certificat attending phy I for use as th	In/M	23b. was decedent pregnant	c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Feta		v		23d. Date of de	
о. О.	The law requires that the death certifica tte has been signed by the attending ph page 2 should be detached for use as th	by Physician/Med	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4□Pregnant at time of o				Month	Day Year
٥	that the ad by the detach	Phy	Part II. Other significant conditions cont	ributing to death but not res	sulting in the underlying cause giv	ven in Part I.	23e. Did tobacco	use contribute t	o the cause of death?
Records,	w requires that been signed to should be det		Prematurity				1 ☐ Yes 2	0 3 □ P	robably 4 Unknown
O O	aw rec s bee	Completed	Bronchopulmonar	y duspla	sia		24a. Was an	24b. Were a	utopsy findings available
_		Com					autopsy performed? 1 ☐ Yes 2 D No	death?	completion of cause of
Viita	ysician: The is certificate hadirector, page	Be	25. Was case referred to medical examiner?	ospital: 🗸	0		th (Check only one)		
of	Physic rithis or rail dir	: To	1 ☐ Yes 2 No 27. Manner of Death	1 X Inpatient 2 28a. Date of Injury	ER/Outpatient 3☐ DOA Oth	4   Nuising In	ome 5 Residence 28d. Describe how inju		ecify)
on	Attending Physician: r death. sctor: After this certifics by the funeral director, i	atlon	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury Wor	rk?  Yes 2 □No	,	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
Division of	i or Attendi after death Director: A I in by the fi	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At h building, etc. (Speci	nome, farm, street, factory, office fy)		28f. Location (Street at City or Town, State	nd Number or R	lural Route Number,
٥	Hospital or Atteno 24 hours after death Funeral Director: tely filled in by the		<b>V</b>						
		Medical	29a. Certifier 1 Certifying Physi (Check only 2 Medical Examin one)	er: On the best of my known:  or: On the basis of examination and manner stated.	owledge, death occurred at the tir ation and/or investigation, in my o	me, date and place, opinion, death occur	, and due to the cause(s rred at the time, date an	i) and manner a id place, and du	s stated. e to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	- 0	29c. Licens	se number	29d. Da	ate signed (Mon	th, Day, Year)
)			Marguet	newsh	-, MU KES	5-000	Apr	114.	2005
			30. Name and address of person who con			e Simi	Rall	M i	121287
	Sta	ite	31. Date filed (Month P. Ryear) 2 20	32. Registrar's Sign	200 North Wolfe	- meet	Baltimore, 1	viaryiano	a a a o i
	Registr		1111 1 2 20	THE STATE OF THE S	B. Anailis				

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** E Winebremer 12:40 FM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Washington Western Maryland Hospital Center Hagerstown Age (In yrs. last birthday) 8. Date of Birth Apr. 13, 1920 If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 9. Birthplace (State or Foreign **Funeral** Days Mary land 1 □ M 2 🔀 F 220-34-0189 Director Usual Residence of Decedent with the Maryland 10b. County 10a State 10c. City. Town or Location 10d. Inside City Limits 28a-f show orient: If Item 27 is marked other than "natural", or Items 23a or 28a-1 shov injury or other traumatic event, It's Medical Examinations. 1X Yes 2 □ No Director Maryland Frederick Woodsboro 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 109 N. Main St. 21798 U.S.A. Completed by Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian Black, White, etc. 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify 3 X Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) nd Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4or 5+) retail dept. store salesperson 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) . Pages 1 and 2 should be fill iment of Health and Mental H tant: If Itam 27 Is marked ot Morgan Eugene Dayhoff Rebecca Catherine Stine 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sandra L. Hevner/daughter 11912 Keymar Rd. Keymar, MD 21757 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department o Important: If any injury or Rocky Hill Cemetery \* 4 ☐ Donation 5 ☐ Other (Specify) 4/12/2005 nr. Woodsboro, MD 22 Name and Address of Facility
Hartzler Funeral Home
404 S. Main St. Woodsboro, MD 21798 21. Signatura of Funeral Service Licensee atharine 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) pronav **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequen Examiner signed by the attending physicien and the detached for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Physician/Medicai as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 📉 No Month Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy rmed? 2 K No certificate 1 Yes Hospital or Attanding Physician: funeral director, Be 25. Was case reterred to medical examiner? 26. Place of Death (Check only one) ٩ 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4√Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After 1 Certification: 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No death. 2 Accident investigation hours after deaf 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only onel To tha within 2 To tha f 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified P0041131 WIL 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1500 Pennsylvania Avenue corpects, M.D Hagerstown, Md 21742 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registra

Amended Item 2 per Physician 04/11/2005 Carroll County, wjl Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 08, 2005 2. DatAp Peath **Physician** DOROTHY DEAN WINSTEAD /Medical 4a. Facility Name (If not institution, give street) of number of the control of t 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BROOKFIELD MANOR ROAD **MIDDLEBURG** CARROLL 5. Social Security Number 481–18–6217 If Under 1 Year if Under 24 Hrs.
Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Y FEBRUARY Birthplace (State or Foreign Country)
 TOWA **Funeral** Y<sup>ear</sup>29,1916 1 M X F 89 Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Director MARYLAND 1 ☐ Yes 2 📉 🗙 0 CARROLL MIDDLEBURG 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5800 MIDDLEBURG ROAD 21757 UNITED STATES Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes XX No Specify: Completed by If Yes, Give Year or Dates: Specify: WHITE 3 Widowed 4 ☐ Divorced permit. Pages 1 and 2 should be filed within 72 h. Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "neturary injury or other treumstic event, the Mudical Once. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 HOMEMAKER DOMESTIC 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be HARLEY SILAS HUTCHENS ARLENE OLA FERGUSON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4009 LITTLESTOWN PIKE, DOROTHY D. MCKINNEY/DAUGHTER WESTMINSTER, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State LORRAINE PARK CEMETERY 4/11/2005 BALTIMORE, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatu Funeral Service Licenses 22. Name and Address of Facility MYERS-DURBORAW FUNERAL HOME, P.A. 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate
Interval Between
Onset and Death Immediate Cause (Final KF Lower 1 day disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to or as a consequence of Examiner Due to (or as a consequence of). an/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy

Physician /Medical Examiner

28a-f show

irel', or iteme 23e or 28a-f shov Examinar must be mutilled at

"neturel",

death with

filed within 72 hours after

Baltimore, Maryland 21215-0036

ath certificate be executed tending physician and Division of Vital Records, P.O. Box 68760,

use as the burial-transit	
should be detached for u	
director, page 2 sh	
in by the funeral	
npletely filled	

by the attached for		in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4□Pregnant at time of death 5□( 9□Unknown	Other (specify)		Month Day Year
igned be de	, ,	Part II. Other significant conditions con	tributing to death but not resulting in the und	derlying cause given in Part I.	23e. Did toba 1 ☐ Yes	cco use contribute to the cause of death? 2 ⊠No 3 ☐ Probably 4 ☐Unknown
cate has been s page 2 should		Hy perten Pulmonar	sion Fibracia,		24a. Was an autopsy performe 1 Yes 2	
nysician nis certifi I director	1	25. Was case referred to medical examiner?  1 Yes 2 No	ospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient	Other	eath (Check only one) Home 5 Residen	VI TONIA
to the hospite or Attending Prhysicien: The law within 24 hours after death.  within 24 hours after death.  completely filled in by the funeral director, page 2:  Medical Certification: To Be Compl		27. Manner of Death  1 Avatural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)  28b. Time of Injury	28c. Injury at Work? M 1 ☐ Yes 2 ☐ No	28d. Describe how	rinjury occurred
s after de Birect de Direct de de la Direct de de la by t		3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At home, farm, stree building, etc. (Specify)	et, factory, office	28f. Location (Stre City or Town,	et and Number or Rural Route Number, State)
thin 24 hour the Funer of the Funer mpletely fill		29a. Certifier (Check only one)  1 ☐ Certifying Phys 2 ☐ Medical Exemin	icien: To the best of my knowledge, death of er: On the basis of examination and/or inve and manner stated.	occurred at the time, date and place estigation, in my opinion, death occ	ce, and due to the cau curred at the time, dat	ise(s) and manner as stated. e and place, and due to the cause(s)
1		29b. Signature and title of certifier	icole MD	29c. License number		d. Date signed (Month, Day, Year)
MA		JoTI. CARICOFE	mpleted c use of death (Item 23a) (Type, Pr	1 1 1 1 1 1 2 2	in Brid	4e MU 31791-952
State Registrar		31. Date filed (Month, Day, Year) APR 11	32. Registrat's Signature	Sparte		V
H 17 Rev 1/2001						

			Please	e Type or Pri				k. <b>Assure A</b> Health and I	•		ble.	
				State of W	aiyiaii		rtificate of		vientai rij	200	n c	11000
		1. Decedent's Nam	ne (First, Middle, I	.ast)					2. Date of D			3. Time of Death
Physici /Medic		Evely:	n .	Mae V	Vilso	n			Month April	Day 12, 20	Year 005	8:00 AM
Examir		4a. Facility Name (	If not institution, g	ive street and number)				4b. City, Town, or	Location of Dea	th 4c. County	of Death	
			1 Mennon		o /ln um	last birthday)	If Under 1 Yea		ntsville 8. Date of B		rrett	
Funeral Director		5. Social Security N 212-22-4		1□ M 2☑ F	85	Yrs.	Months Day		(Month, D	27,1919	9. Birthplac Country	e (State or Foreign Virginia
		Usual Residence o							pept.	27,1919	WESL	ATISTITA
larylan show	Ļ	10a. State	10b. County		10c. Cit	y, Town or Lo	cation				1	Inside City Limits
the Mi	Director	Md 10e. Street and Nu		rett			0 a	kland		10g. Citizen of V		1 ☐ Yes 2 ☑ No
filed within 72 hours efter death with the Maryland Hygiene. Hygiene. Then "netural", or items 23e or 28e-f show ent, the Medical Evarrant must be notified at				sscut Road			Tot. Zip Code	21550		TOG. CILIZETT OF V	USA	
death	Funeral	11. Marital Status	SELL CLO	12. Was Decedent	Ever in U,	S. 13.	Was Decedent of	Hispanic Origin? (S ban, Mexican, Puerl	pecify Yes or N		e - American	
or Ita		1 Never Marr	ied 2□ Married	Armed Forces? 1 ☐ Yes 2 🖺 If Yes, Give	No		1 Yes, specify Cu 1 □ Yes 21☑ No		o Hican, etc.)	1000	k, White, etc	
hours ural',	d by	3 🖾 Widowed		Year or Dates:						Specify		ite
in 72 in 72	lete		15. Decedent's cify only highest g	rade completed)		16a. Deced (Give	dent's Usual Occi kind of work don DO NOT use retir	upation e <i>during m</i> ost of wor ed)	king	16b. Kind of Bu	ısiness/Indus	try
d with giene. r ther	Completed	Elementary/Seco	-	College (1-4or	5+)		House				Home	
e filec al Hyg othe vent,	BeC	17. Father's Name		st)			11000		ne (First, Middle	e, Maiden Surnam		
ould b Ment arkad atic e	To	Charles		Raymond	S	e11		Ina	Pear	r1 1	Root	
nd 2 should be filed within and Mental Hygiene. 27 is marked other then rice treumstic event, the Men		19a. Informant's N					_	et and Number or Ru				,
1 and Health em 27		20a. Method of Dis		aker/Daughi			/ Pysel.	l Crosscut	Date Date	OakLand 20c. Location		
Pages nent of I nt: If ite		1 ☑Burial 2		Removal from State	С	emetery, crer	natory or other pi				•	
permit. Pages 1 and 2 Department of Health a important: if item 27 is eny injury or other tree		21. Signature of Fu			Gar		O. Mem.  Name and Add	Gardens   ress of Facility		32 S. See		
Den Pen Pen Pen Pen Pen Pen Pen Pen Pen P		· R	M. Olor	Lungth		St	ewart Fi	ineral Ho		Oakland,		
		23a. Part1. Enter t	the disease, of co	mplications that causer y one cause on each li	d the death						Ar	oproximate terval Between
Physician		SHOOK, OF HOU	artiuliule. List on				1 ^				Öi	nset and Death
/Medical Examiner		Immediate Cause disease or condition resulting in death)	(Final on	a. Covor	ren	, an	tany D	island.			1	year
	ē	robuiling in doutin,		A1	Due to (o	as a consec	quence of):				0.1	1 214-20.
executed in and iel-trensit	Examiner	Comment to the ties of		b. 11trial	Due to lo	1145411	uence of):				101	thy iems
		Sequentially list co if any, leading to in cause. Enter Unde Cause (Disease or	nmediate erlying	Advan	2 1	Pan	Line on!	s disea	22.		AA.	ANY YEARS
ate be shysicia the bu	dical	that initiated events resulting in death)	s T	c. 110000	Due to (or	r as a conseq	uence of):	5 041040			1000	
se as	/Me			1 Diabe	te	s /	rellit.	us			MA	NYTEARS
eath c	Physician/Medic											
t the d by the	hysl	Other signif	icant conditions	contributing to death b						itobacco use coi ]Yes 2.2€No		e cause of death?
s that	by P	Remai	ker,	Hyperte	Jusi	an	Urosa	2/5/5	*	102 20110		1) 4 Olikilowii
The law requires that the death certificate are has been signed by the ettending physi page 2 should be detached for use as the		Near 11	PMATI A	Thrombo	6 C C	Q.T	-A0H VII	DC BCCLLA	24a. Wa	s an autopsy formed?	availa	autopsy findings ble prior to
E 25	Completed	A . V	^			)	WIN AL	o coc cas			of dea	letion of cause ath?
: The cate t		HUREUS		EREMIA	•				1 🗆	Yes 2 No	1□Y	es 2□ No
sicien: The law certificate has b	o Be	25. Was case refer examiner?		Hospital:		50/0 · · ·		26. Place of Dea				
3 Phys erthis	n: To	1 ☐ Yes 2 ☐ 27. Manner of Deat	h	1 ☐ Inpatie	rv	ER/Outpatier 28b. Time of	I 3LI DOA	4 EX Nursing F		sidence 6 Oth how injury occur		
ath. r: Afte	atio	1XQNatural 2 ☐ Accident	5 Pending investigati	(Month, Da	y Year)	Injury		ork? ⊒Yes 2⊒No				
To the Hospitel or Attending Physicien: The is within 24 hours effer death.  To the Funerel Director: Affer this certificate ha completely filled in by the funeral director, page	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could not determine	be d 28e. Place of Inj building, et	ury - At ho	ome, farm, str	eet, factory, office	Э		(Street and Numb own, State)	er or Rural R	oute Number,
pitel o	Ce	20- 0-44										
24 hos Fune etely	edical	29a. Certifier (Check only one)	2 ☐ Medical Exa	Physician: To the best sminer: On the basis of and manner st	f examinat	wledge, death tion and/or inv	n occurred at the vestigation, in my	time, date and place opinion, death occu	, and due to the rred at the time	e cause(s) and ma e, date and place,	inner as state and due to th	d. e cause(s)
To the within To the Comp	Me	29b. Signature and	itle of certifier	1			29c. Licer	nse number		29d. Date signe	d (Month, Da)	y, Year)
			School	Namal	), L	U.		D005865	5	4/12/0	5.	
4				completed cause of d	,	, , , , ,	Print)					
-		32 Cov povo 31. Date filed (Mon		E, GRANTS			45 2	1536.				
Sta Registr		C1. Date med (MON	AFR 1 3	2005 32. Registr	ai s Signa	AL.	A 00					
				1000	WATE TOWN	Astronom A	AND THE REAL PROPERTY.					

			For 1 State	State of Ma	aryland	-				and M	•	()	0.05	11.010
			1 - State Registrar			Cel	rtificat	e or L	Jean		2. Date of De	Reg. No.	000	1 4 0 1 0
	Physici	an	Decedent's Name (First, Middle, Last								Month	Day	200 <sup>Year</sup>	3. Time of Death
1	/Medic			REBECCA		WARD				<b>15</b>	April	<u></u>		12:25p™
1	Examin	er	4a. Facility Name (If not institution, give						Location of				ounty of Death	
			Avalon Manor Heal  5. Social Security Number 6. S			ast birthday)		1ager	stowr If Under		8 Date of Ri		ashingt	pplace (State or Foreign
	Funeral Director			□M 2□XF	78	Yrs.	Months		Hours	Min.	8. Date of Bi (Month, D June 13	3, 192	6 Ma	ryland
	land ow		10a. State 10b. County		10c. City	, Town or Lo	cation							10d. Inside City Limits
	Mary -f sh	ţō	Maryland Washin	gton	Н	agerst	own							1 ☐ Yes 2 🂢 No
	r 28s	Director	10e. Street and Number	-			10f. Zip	Code				10g. Citize	n of What Co	untry?
	ours after death with the Marylar rai", or Items 23a or 28a-f show Examilier must be nutified at	a D	18911 Waldron Pl	ace				21742	<u> </u>			U	.S.A.	
	deat	Funerai	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.	S. 13.	Was Dece	dent of Hi	spanic Ori	gin? (Sp	ecify Yes or N Rican, etc.)	0- 14.	. Race - Amer Black, White	
ဖွ	or Ite	교	1 Never Married 2 Married	1 ☐ Yes 2 🐧 I If Yes, Give	No		1 ☐ Yes		Specify:	, , , ,	1 110411, 010.7		pecify:	, 610.
8	hours tural',	d by	3 X Widowed 4 □ Divorced	Year or Dates:				-д-	- Op 0y.				W	hite
21215-0036	CI CE LA	Completed	15. Decedent's Ed (Specify only highest gra	lucation de completed)		16a. Dece (Give	kind of wo	rk done d	urina mos	t of work	ing	16b. Kind	of Business/I	ndustry
12	I within 7. jiene. r than "n the Madi	E D	Elementary/Secondary (0-12)	College (1-4or 5	5+)		DO NOT u		,			Owi	n Home	
2	Hygi Hygi ther nt, I		17. Father's Name (First, Middle, Last)		Ţ	пс	memal	CET.	18. Mothe	r's Nam	e (First, Middle			
au(	ed la de	) Be	_	ebraker	S	chloss	on			sabe				Chaf-
Maryland		ဥ	19a. Informant's Name/Relationship					(Street a			⊥⊥ al Route Numb	Lakin er City or T		Shafer in Code
<b>≅</b>	D C N E		Sarah A. Ward	Daughter			-				fer, Pe	-		
ē,	s 1 and if Health item 27 other tr		20a. Method of Disposition		20b. PI	ace of Dispo	sition (Na	ne of	!		Date		tion - City or 1	
آ و	2 ° = 5		1 □XBurial 2 □ Cremation 3 □  1 □ Cremation 3 □ Other (Specification 5 □ Other (Specification 5)			emetery.crer se Hil				04-1	2-05	Hager	stown	Maryland
Baltimore,	permit. Pag Department Important: any injury c		21. Signature of Funeral Şervice Licer						1			_		,
B	permit. Departr Importa any inj		Phool-	Krady		A	ndrev N Fas	√K. st Δn	Coffr	nan (	Funeral	Home	, Inc.	Md. 21740
			23a. Part1. Enter the disease, or com	plications that aused	the death	. Do not ent	er the mod	de of dying	, such as	cardiac	or respiratory a	rrest,	SCOWIT,	Approximate Interval Between
	Physician		shock, or heart failure. List only immediate Cause (Final	one cause of each in	61 6	H	e an H	F	mil	10.				Onset and Death
	/Medical		disease or condition resulting in death)	a. Due to (gras	a consequ	ience of):			/- (/-					Onset and Death
	Examiner		Convention by list conditions	, ,	lalu	ular	, hu	orto	VIC	ase	post	mec	haicd	vowes.
	D =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequ	ence of):					1			
	acute and trans	Examiner	that initiated events	c	mer	ua								
760,	te be executed ysician and e burial-transit	Ë	resulting in death) Last	Due to (or as	a consequ	ience of):								
	3 × 5	dicai	•	d										
x 68	that the death certifica ed by the attending ph detached for use as th	Physician/Med	IF FEMALE:	23c. If yes, outcome	of progne	201								
Вох	atten atten for us	lan	23b. Was decedent pregnant in the past 12 pronths?	1 Live birth	2 Fetal	death 3[	Ectopic p					230	<li>d. Date of delimental delimen</li>	very Day Year
o.	the d	ysic	1 ☐ Yes 2 1 No 9 ☐ Unknown	9☐ Unknown	Curre or de	atii 5	TOUISI (St	Jecity)						
Δ.	The law requires that the tte has been signed by th bage 2 should be detache		Part II. Other significant conditions of	ontributing to death b	ut not resu	Ilting in the u	nderlying o	ause give	n in Part I.		23e. Did	tobacco use	contribute to	the cause of death?
ds,	uires signe Id be	d by									10	Yes 2 🗆	No 3□Pro	obably 4 Onknown
of Vital Record	w requir been si should	ompieted						-			24a. Wa:	s an	24h Were aut	topsy findings available
Re	The fav	g									auto perf	psy ormed?	prior to death?	completion of cause of
a		e Co	25. Was case referred to medical							- 15	1 Yes		1 ∐ Yes	2 No
Ξ		o B	examiner?	Hospital:	ont 2 🗆	ER/Outpatier	t all Do	Othe	r /	*	h <i>(Check only</i> me 5 □ Res		Other (Spec	2(64)
o			27. Manner of Death	28a. Date of Inju	irv	28b. Time o		28c. Injury Work		Ising Hu	28d. Describe			ary)
on	Attending Phr r death. ector: After thi by the funeral	tio	1	(Month, Da	y Year)	Injury	м		:? ∕es 2 🔲 I	No				
Division	Atter r dea ector by the	Hice	3 Suicide 6 Could not be determined	28e. Place of Inj	jury - At ho	me, farm, str	eet, factor	y, office					Number or Ru	ral Route Number,
Ö	s afte	Certification:	4   Homicide	building, et	.с. (Зреспу	7					Chy or 10	wn, State)		
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the to	edicai (	(Check only 2 Medical Exen	ysicien: To the best niner: On the basis o										
	the I hin 2 the I	Med	one)	and nanner sta										
	7 Kil		29b. Signature and title of certifier					C. License	622	-22		1/1	signed (Month	., Jay, 1841)
			<b>/</b>	1	·, ·u			- 00		-3		7/	./"	
hil	-15		30. Name and address of person who	•		-		٦٥٥٥٠	net our	o M	anvlana	1 2174	n	
JH	Sta	to.	Prazeen Bolarum 31. Date filed (Month Per Year)	1 MD . 340			et, i		SCOW	ı, M	aryland	1 61/4	<u> </u>	
		TG.	AUUTT	UUD Real	3	an by	N. 250 a	-						

			For State Registrar	State of Ma	ryland /	-	artmen tificati					Røg. No.	2111	15	A vertical and a second and a s	-
П	Physicia	an	1. Decedent's Name (First, Middle, Las WALTER BERNAF	•	EN						2. Date of De Month April	12 <sup>Day</sup>	200	Year 5	3. Time of 5:30	
	/Medic Examin		4a. Facility Name (If not institution, give						Location			4c.	County of	f Death		
			Hartlet Hall 1  5. Social Security Number 6. So		OME (In yrs. last b		Poco	MOK			8. Date of Bi		orce		r ace (State of	Foreign
H	Funeral Director			M 2□F	82	Yrs.	Months		Hours	Min.	1 1 / 1	7/19	22 M	linn	esota	L
	and		Usual Residence of Decedent  10a. State 10b. County		10c. City, To	wn or Lo	cation							11	Od. Inside Cit	y Limits
	Maryll	to	VA Accomac	ς	Green	bac	kvil	le							1 🗌 Yes	2 No
	or 28s	Funeral Director	10e. Street and Number				10f. Zip					•	zen of Wi	nat Coun	try?	
	eath w	erai	3326 Scimitar	Way  12. Was Decedent E	ver in U.S.	13. \		356	spanic O	rigin? (Spe	acify Yes or N		USA	- Americ	an Indian.	
٩	be filed within 72 hours after death with the Maryland ital Hygiene. d other than "naturel", or Itame 23e or 28a-f show event, the Medical Examiner must be motified at	Fun	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 XYes 2 ☐ No	0		if Yes, spec 1 ☐ Yes	4.7	n, Mexica Specify		ecify Yes or No Rican, etc.)		Black	, White,	etc.	
000	hours turef,	ed by	3 Widowed 4 □ Divorced  15. Decedent's Ed	li Yes, Give 1 4	1			7				1 teh Ki	Specify: ind of Bus	Whi		
215	hin 72 in "nai	Completed	(Specify only highest gra			(Give	dent's Usua kind of wo DO NOT us	rk done d se retired)	luring mo: )	st of worki	ing	100. K	nd or bus	411622/1110	lustry	
21	filed wit Hygiene other tha ent, the		10		C	ust	odia	n	10 14-45	ada Nama	/Final Adiabatic		ucat			
and	e d ia e	To Be	17. Father's Name (First, Middle, Last)  Jalmar Wiljane							da 1	e (First, Middle Maki	e, Maiden	Sumame	"		
ary	s 1 and 2 should be if Health and Menta Item 27 is marked other traumatic even		19a. Informant's Name/Relationship (	• • • •				,			al Route Numb					
e, e	1 and 2 Health tem 27		Lynn Wiljanen/ 20a. Method of Disposition	daughter	20b. Place				ar W		Greenk		VIII ocation - C	-		356
altimore, Maryland 21215-0036	permit. Pages 1 Department of the Important: If Ite any Injury or ot once.		1 Burial 2 Cremation 3 4 Donation 5 Other (Specific	Removal from State	cemet	tery, crer	matory or o	ther place			/2005			-		1804
Ball	permit. Depart Import any Inj		21. Signature of Funeral Service Licer	Seum		lbl		Melac	n Fur	eral I	bre, P.					
	THE REAL PROPERTY.		23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused tone cause on each line	the death. De	o not ent	ter the mod	le of dying	g, such a	s cardiac o	or respiratory	arres O	COTICKE	MD 2	Interval Bet Onset and D	yeen Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. METASTA			N C	ANCE	ER					_	011001 4110 1	
	Examiner		Convention line and divine	Due to (or as a	consequenc	e or):										
	be sit	iner	Sequentially list conditions, if any, bauting to innustrate cause. Enter Underlying Cause (Disease or injury	Dua to (or se a	consuperno	e offi										
<u>,</u>	execut n and ial-trar	Examiner	that initiated events resulting in death) Last	c. Due to (or as a	consequenc	e of):										
8760,	cate be executed bhysician and the burial-transit			d												
မှ	eath certific attending pl	/Mec	IF FEMALE:	23c. If yes, outcome of	of pregnancy								23d. Date	of delive	ını	
Box	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	1 ☐ Live birth 2 4 ☐ Pregnant at t 9 ☐ Unknown	2 ☐ Fetal dea		∃Ectopic p ∃ Other (sp					1	Mon		,	'ear
P.O.	that the de ned by the a detached f	Phys	9 ☐ Unknown  Part II. Other significant conditions of		t not resulting	n in the u	nderlying (	Sauce cive	an in Part	1	23e Did	tobaccou	use contri	bute to th	ne cause of d	eath?
Vital Records,	luires than n signed I	d by				<b>y</b>		, a 5 5 5 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7	311 111 7 (41)						ably 4 🗀	
000	le law require has been si ge 2 should b	Completed									24a. Wa	s an	24b. W	ere auto	psy findings a	available
E E	: The cate his page	Сош					<u> </u>				per	formed? 2 DM	de de	eath?	-	
Zi Zi	siclan certifi irector	o Be	25. Was case referred to medical examiner?  1 Tyes 2 No	Hospital: 1 ☐ Inpatier	nt 2 🗆 ER/	Outpatio	nt 3 D0	Cthe	55178	-	h <i>(Check only</i> ome 5 ☐ Res		€ □Otho	r (Specif	(1)	
Division of	ng Phy Iter this neral c	$\vdash$	27. Manner of Death 1 ☐Natural 5 ☐ Pending	28a. Date of Injury (Month, Day)	y 28t	o. Time o		28c. Injury Work			28d. Describe				r)	
Sio	tendir Jeath. tor: Al	catic	2 Accident investigation 3 Suicide 6 Could not b	1			М	10	Yes 2		28f. Location	/Ctennt or	and Marina branch		/ O= 4= 1/	
≥ O	al or A s after il Direction	Certification:	4 ☐ Homicide determined	28e. Place of Inju building, etc	. (Specify)	, rarm, si	reet, ractor	y, onice			City or To	own, State	e)	I OI MUIZ	ii Houle ivaiii	Jei,
	To the Hospital or Attending Physiclan: The I within 24 hours after death.  To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	edical (		nysician: To the best on niner: On the basis of and manner star	examination											)
	To the I	Me	29b. Signature and little of certifier						e number						Day, Year)	
ı			30. Name and address of person who					0006	2172			4	(13/	200	5	
T	341		SHARAD R SATYA	L 1604	MARKE	T S	)	Polo	MOK	e 1	MD 2	1851				
	Sta		31 Date filed (Month Day Year)		r's Signatur	· A	posti	9								
	Registi	ar	131 11 20 0	1		-/										

			Amend I		per	Dr.,G	343 e	95618/	872	beath			Reg	20 (	)5	14012
Physicia	n	Decedent's Name	e (First, Middle, I	Last)								2. Date of Month	Death	Day	Year	3. Time of Death
/Medic	al	Blaine Co			umbar)			4b. City, To		Location	of Dooth	April	10	2005 4c. Count		12:23 p.m
Examin	=1	Garrett C				tal		Oaklar		Location	Death					
Funeral		5. Social Security N		Sex 1MM 2□F		In yrs. last		If Under 1	/ear	If Under		8. Date of	Birth	Garre		place (State or Foreign
Director		215-26-99	59	1ØM 2□F		74	Yrs.	Months D	ays	Hours	Min.	Jan.	25,	1931	Mary	y Land
and w		Usual Residence of 10a. State	10b. County		1	Oc. City, To	own or Lo	cation								10d. Inside City Limits
Manyi -1 eho	ō	MD	Garrett			Accid										1 ☐ Yes 2 🛣 No
n the	Director	10e. Street and Nur				110010	delle	10f. Zip Co	ode				100	. Citizen of	What Cou	ntry?
IdryIdric ZIZIS-UU30 2 should be filed within 72 hours after deeth with the Maryland and Mental Hygiene. Is marked other than "natural", or Itema 23a or 28e-1 show aumatic event, the Madical Examinar must be notified at	a	177 Blai	ne Wilt	Lane				21	.520	)				USA	4	
or dee	Funeral	11. Marital Status	v	12. Was De Armed F	Forces?	er in U.S.	13. V	Vas Deceden Yes, specify	t of His Cubar	spanic Ori n, Mexicar	gin? (Sp	ecify Yes or Rican, etc.)	No-		ce - Ameri	can Indian, etc.
rs afte	by F	1 ☐ Never Marri 3 ☐ Widowed	ied 2⊠ Married	1 □ Yes If Yes, G Year or	2 (Ž) No Sive		1	□Yes 2🎗	No	Specify:				Speci		
Maryland ZIZIS-UU30 nd 2 should be filed within 72 hours alt lith and Mental Hygiene. 27 is marked other than "netural; or traumatic event, the Modical Exami	edr	0 🗆 🗆	15. Decedent's		Da165.	10	6a. Deced	lent's Usual C	Occupa	ition			16	b. Kind of E		ite dustry
Med 7.	plet	(Speci	ondary (0-12)		1) (1-4or 5+)		(Give life. [	kind of work o	done di retired)	uring mos	t of work	ring				,
A wit	Completed	5	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		(1 10.01)		Coal	Miner						Coal		
<b>€</b> d <u>a e</u> d ∈	Be	17. Father's Name		st)					1			e (First, Mid		iden Sumai	me)	
aryia should ind Men ind Men umarke	욘	Truman W		Æ 5:4				. 1000000000000000000000000000000000000	- !			Bitting				
Mai d 2 st d 2 st th and th and traun traun		19a. Informant's Na	·					g Address (S								21520
Te, IV	1	Martha W 20a. Method of Disp		<u> </u>		20b. Place	a of Dispos	sition (Name	of	1		Date	-	c. Location		
Peges nent of l ont: If Its			☐Cremation 3 5 ☐Other (Spe		n State			cemet	,	′ I	ril	13.200				Maryland
를 교육원을 다		21. Signature of Fu				D100.		179 Mí					-		-	
Dapa Impo any le		Dely	Sur ()	bem	au		- P.	O. BOX	27	5, G	rant	svill	2, I	Marvla	and 2.	1536
		23a. Part1. Enter the shock, or hea	he disease, or co	mulications that	caused th	e death. D										Approximate Interval Between
Physician		Immediate Cause ( disease or condition	(Final		01	1.0/	oto					velc				Onset and Death
/Medical Examiner		resulting in death)	1			constquenc	ce of):	11	-1							suge
		Sequentially list co	nditions.	b	ASCVD											
led sit	Examiner	Sequentially list co- if any, leading to in cause. Enter Unde Cause (Disease or that initiated events	nmediate orlying injury	Due to	o (or as a c	onsequenc	ce or):									
be executed iclen end burial-transit	xar	that initiated events resulting in death) I	Last	cDue to	o (or as a o	consequence	ce of):									
ete be executed nysiclen end he burial-transit	cal			d.												
tificet g phy es th				u												
death certifice e ettending ph	by Physician/Med	IF FEMALE: 23b. Was deceden		23c. If yes, o		pregnancy		Ectopic pregr	nancv					1	ate of deliv	•
at the death by the etter	slc	in the past 12	□No		gnant at tin	ne of death		Other (speci						М	onth	Day Year
d by	된	9 ☐ Unknown Part II. Other signif		anatributing to	dooth but		- i- M			- ia D- 4 l		222 0	id taba			the server of death?
ures that signed to do be det	φ	artii. Guior sigiii		diogen			hac	logilying caus	sa giva	инган.		19		2 🗆 No	3 🗀 Proi	the cause of death?
w requir	etec			7			rice	1				-	-			
The law requires that the the has been signed by the bage 2 should be detected.	Completed			· · · · · · · · · · · · · · · · · · ·								24a. W	ras an utopsy erforme		prior to co death?	opsy findings available empletion of cause of
ifficate or. pa	ပိ	25. Was case refer	red to medical	1						OF Blace	of Door	1 ☐ Ye		XVo	1 🗆 Yes	2 □ No
2 3 2	0	examiner?		Hospital:	Inpatient	2 □ ER/	Outpatien!	t 3□ DOA	Other			ome 5□R		ce 6.⊟Ot	her (Speci	6)
D = = 0	١	27. Manner of Deat	h		e of Injury onth, Day Y		b. Time of Injury		Injury	at		28d. Descri				
endin eath. or: Af	atlo	1 ☑Natural 2 ☐ Accident	5 Pending investigat	ion	mun, Duy n	OLD/	тциту	М		es 2 🗆	No					
DIVISION  If or Attending  If or Attending  If or Attending  Director: Attending  In by the fune	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could not determine	289. Plac	ce of Injury ding, etc. (	· At home (Specify)	, farm, stre	et, factory, o	ffice			28f. Locatio City or	n <i>(Stre</i> Town,	et and Num State)	ber or Rur	al Route Number,
LIVISION Hospital or Attending 4 hours effer death. Funerel Director: After			<i>J.</i>									à .				
Hosp 24 ho Fune tely fi	Medical	29a. Certifier (Check only one)	2 Medical Ex	Physician: To the	basis of ex	xamination	dge, death and/or inv	occurred at t restigation, in	my opi	e, date an inion, dea	d place, th occur	and due to i red at the tin	the cau ne, dat	se(s) and m and place	anner as s , and due t	stated. o the cause(s)
To the Hospitel or Attending is within 24 hours effer death. To the Funerel Director: Afler completely filled in by the funer	Mec	29b. Signature and	Attle of contier	and ma	inner state	u		29c. L	icense	number			290	I. Date sign	ed (Month,	Day, Year)
⊢≯⊢ŏ		XX			-(1											
1/_	ŀ	30. Name and addr	ss of person wh	o completed car	use of dea	th (Item 23	a) (Type I		0239	919			<u></u>			
Ut		Robert A				•			_	<b>3-1-7</b> -	5			0155	_	•
		TONGEL F H	· COLUTE	DVT LID'	JII I	V - FO	חדקון	STroot	٠, ،	)AKIA	na .	IVI CONTRA		/ 1 ~ ~ /	1	

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** Year Youssef April 9, 2005 Ibrahim Abdelsalam 4:25 a M /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 7105 Sonnett Court Montgomery Derwood | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month), Day, Year) | Min. | Min. | March 27 1919 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1X M 2 F Director 212 94 2258 86 Yrs. Egypt Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits in than "natural", or Items 23a or 28a-f show the Medical Exp. after must be notified at 1 □ Yes 2X No Maryland Montgomery Derwood Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20855 7105 Sonnett Court USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 20 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2000 Specify: þ 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Administrator Computer Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Abdelsalam Youssef Taman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important; If Item 27 is
any injury or other trau Galila Youssef / Wife 7105 Sonnett Court Derwood, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition
1 Burial 2 □ Cremation 3 □ Removal from State 20c. Location - City or Town, State \* 4 ☐ Donation 5 ☐ Other (Specify) Ft Lincoln Cemetery \4/9/2005 Brentwood, Maryland 21. Signature of Funeral 3 ryo Livensee 22. Name and Address of Facility Hines Rinaldi Funeral Home 11800 New Hampshire Ave Silver Spring, MD 20904 ant 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Frysician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate causa. Entar Underlying Cause (Disease or injury that inflated events Due to (or as a consequence of): burial-transit resulting in death) Last Due to (or as a consequence of) P.O. Box 68760, Physician/Medical the as 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Year Month Day 4☐Pregnant at time of death 5 Other (specify) detached to 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by RENAL INSUFFICIENCY, CHRONIC OBSTRUCTIVE 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown PULMONARY DISEASE DIABETES MELLITUS, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an HYPERTENSION, CORONARY ARTERY DISEASE performed 1 ☐ Yes 2 ☐ No 1 ☐ Yes Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification; To 27 Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1. Natural 5 Pending To the Hospital or Attending within 24 hours after death.

To the Funeral Director: Afte completely filled in by the fun 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature a D26571 f person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year)
APR 11 2005

MD 10215 FERNWOOD RO #401 BETHESOA, MD 20817

32 Registrar's Signature

Aa. Facility Name (If not institution, give street and number)   Ab. City, Town, or Location of Death   Ac. County of Walkers ville   Fr.	ederick  9. Birthplace (State or Foreign Maryland  10d. Inside City Limits 1   Yes 2   Xe No  nat Country?  . A.  American Indian, White
Au Facility Name (If not institution, give street and number)   Au Facility Name (If not institution, give street and number	f Death ederick  9. Birthplace (State or Foreign Maryland  10d. Inside City Limits 1 Yes 2 Xes No mat Country? . A American Indian, , White, etc.  White iness/Industry
The state of the s	ederick  9. Birthplace (State or Foreign Maryland  10d. Inside City Limits 1  Yes 2 12 No  nat Country?  . A.  - American Indian, , White, etc.  White iness/Industry
Funeral Director    Social Security Number   218-30-8795   1	9. Birthplace (State or Foreign Mary land  10d. Inside City Limits 1
Director    State   10b. County   10c. City, Town or Location   10d. Street and Number   10d. St	Maryland  10d. Inside City Limits 1 □ Yes 2 ▼ No nat Country? . A American Indian, , White iness/Industry
Maryland Frederick Woodsboro  10a. State 10b. County Maryland Frederick Woodsboro  10c. City, Town or Location  Woodsboro  10c. City, Town or Location  Woodsboro  10d. Street and Number 10d. Zip Code 10d. Citizen of Wr  9928 Gravel Hill Rd. 21798 U.S.  11. Marital Status 12. Was Decedent Ever in U.S. Amed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Black, Mexican, Puerto Rican, etc.) 14. Race Black, If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	1 □ Yes 2 XNo nat Country? . A American Indian, , White iness/Industry
Maryland Frederick  Woodsboro  10e. Street and Number  9928 Gravel Hill Rd.  21798  U.S  11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 3 Widowed 4 Divorced  15. Decedent's Education  16b. Kind of Bus	1 □ Yes 2 XNo nat Country? . A American Indian, , White iness/Industry
That y tail the tried et lick woods boto  10e. Street and Number  9928 Gravel Hill Rd.  11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces? 1. Syes 2 No If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  11. Was Decedent Ever in U.S. Armed Forces? 1. Syes 2 No If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  12. Was Decedent Ever in U.S. Armed Forces? 1. Syes 2 No If Yes, Specify: 1. Syes 2 No Specify: 1.	.AAmerican Indian, White, etc. White
9928 Gravel Hill Rd. 21798  U.S  11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced  15. Decedent's Education  16b. Kind of Business  16b. Kind of Business  16b. Kind of Business  16b. Kind of Business  17c. Ves. Specify: U.S. A Race Black, Specify: U.S. A Race Blac	.AAmerican Indian, White, etc. White
11. Marital Status 12. Was Decedent Ever in U.S. Amed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race Black, 15. Yes 2 Do If Yes, Specify: 15. Decedent's Education 16b. Kind of Businers	White, etc. White iness/Industry
1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 No If Yes, Give Year or Dates: 1953-56 1 Yes 2 No Specify: Specify: Specify:	White iness/Industry
Year or Dates: 1 9 3 3 Wildowed 4 & Divorced Year or Dates: 1 9 5 3 - 5 0	iness/Industry
(Specify only highest grade completed)  (Give kind of work done during most of working life. DO NOT use retired)	1 grocery
15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Maiden Sumame.	
Elementary/Secondary (0-12)  To pure the property of the prope	)
Clyde M. Young Irene Winpigler	
Clyde M. Young    State   Clyde M. Young   Irene Winpigler	
20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - C	
TX□ Burial 2□Cremation 3□Removal from State  Commetery, crematory or other place)  Mt. Hope Cemetery 4/7/2005 Woodsb	oro.MD
21. Signalue of Foneral Service Licensee ( / 22. Name and Address of Facility Hartzler Funera	
20a. Method of Disposition    X   Burial 2   Cremation 3   Removal from State	D 21798
23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.	Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)  Cerebral edema	1 mo.
Examiner  Due to (or as a consequence of):	1 (16) 44
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying  Brain metastases  Due to (or as a consequence of):	1 /yr.
f any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Adeno Calung  Due to (or as a consequence of):  Due to (or as a consequence of):	2-5 yrs.
Cause. Enter Underlying Cause. (Disease or rillury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):	
to to the life	
y ji d for a few and the past 12 months?  If FEMALE:  23c. If yes, outcome of pregnancy  23d. Date  1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy  23d. Date  1 □ Live birth 2 □ Fetal death 5 □ Other (specify)	of delices
IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1   Voc. 2   Ne.   23c. If yes, outcome of pregnancy   1   Live birth   2   Fetal death   3   Ectopic pregnancy   Months?   4   Pregnant at time of death   5   Other (specify)	of delivery h Day Year
O e to	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contributing to death but not resulting in the underlying cause given in Part I.	oute to the cause of death?
Toping the control of	3 ☐ Probably 4 ☐ Unknown
TEA Yes 2 INO 3	ere autopsy findings available ior to completion of cause of
	eath? ☐Yes 2☐No
25. Was case referred to medical examiner?  1	daughtz-3
To the section of the	
See Place of Injury At home, farm, street, factory, office    Continue of the property of the	
27. Manner of Death  1	r or Rural Route Number,
A language of the control of the con	
29a. Certifier 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and man converted at the time, date and place, and due to the cause(s) and man converted at the time, date and place, and man converted at the time, date and place, and man converted at the time, date and place, and man converted at the time, date and place, and man converted at the time, date and place, and man converted at the time, date and place, and due to the cause(s) and man converted at the time, date and place, and due to the cause(s) and man converted at the time, date and place, and due to the cause(s) and man converted at the time, date and place, and due to the cause(s) and man converted at the time, date and place, and due to the cause(s) and man converted at the time, date and place, and due to the cause(s) and man converted at the time, date and place, and due to the cause(s) and man converted at the time, date and place, and due to the cause(s) and man converted at the time, date and place, and due to the cause(s) and man converted at the time, date and place, and due to the cause(s) and man converted at the time, date and place, and due to the cause(s) and man converted at the time, date and place, and due to the cause(s) and man converted at the time, date and place, and due to the cause(s) and due	
	(Month, Day, Year)
D14626 April	5, 2005
WJL  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	
P.G. Rausch 501 W. 7th St. Frederick, MD 21701	
State Registrar APR 1 1 2005 32. Registrar's Signature	

		1 - For State Registrar		State of M	aryland		artment o		Mental H	ygiene Reg. No.	2000	I I was a
Physic /Medi			ne (First, Middle, Las	ZOBER					2. Date of D Month		Year 2005	3. Time of Death
Examin Funeral Director		4a. Facility Name ( CHEST EX  5. Social Security N  188-26-4  Usual Residence of	RIVER A. Number 6. S. 1070	street and number)	4		0		MD	lirth	County of Death  KENT  9. Birth  PA	unlace (State or For
show Test	_	10a. State	10b. County		10c. City,							10d. Inside City Lin
a or 28e-f s Lbs notifie	Director	MD  10e. Street and Nu  107 We	Kent mber est Cross			Salena	10f. Zip Coo 216			10g. Citiz	en of What Co	1 ☐ Yes 2 🔯 untry?
ene. then "neturel", or items 23a or 28e-f show na Macifiel Examination ust be matified at	Completed by Funeral	11. Marital Status	ried 2 Married	12. Was Decedent Armed Forces 1 Tyes 2 X If Yes, Give Year or Dates:	?		Was Decedent f Yes, specify 0 1 ☐ Yes 2 🛣	of Hispanic Origin? Cuban, Mexican, Pu No <i>Specify:</i>	(Specify Yes or the erto Rican, etc.)		4. Race - Amer Black, White Specify: Wh	
t of Health and Mental Hygiene. If item 27 is marked other then "netur or other treumetic event, the Modical	mpieted	Elementary/Sec	15. Decedent's Eccify only highest gra	lucation de completed) College (1-4or	5+)	16a. Dece (Give life.		cupation one during most of v tired)	vorking	16b. Kin	d of Business/I	ndustry
and Mental Hygiene. Is marked other then eumetic event, the M.	To Be Co	17. Father's Name	(First, Middle, Last) Outkiewicz			TOMOMO	ikei		<sub>lame (First, Midd</sub> ena Lisi	le, Maiden S		
Health and Men tem 27 is marke other treumetic			lame/Relationship (7			644 1	Mud Mil	eet and Number or 1 Road, C	Rural Route Num amden Wy	ober, City or oming	Town, State, Z , DE 19	ip Code) 934
Department of Health importent: if item 27 any injury or other to 2009.		° 4 □ Donation	☐ Cremation 3 ☐ 5 ☐ Other (Specify	<u> </u>	сел	netery, crer npton	sition (Name or natory or other Cemete:	ry Apr	Date il 8, 20	05 Cr		MD
Department in Importent: if any injury or once.		21. Signature of F	uneral Service Licen	888		22	Fellow:	dress of Facility S, Helfen Ser Road,	bein & N	ewnam	Funera	1 Home, 1
hysician and hysician and the burial-transit	licai Examiner	Sequentially list or if any leading to it cause. Enter Und Cause (Disease of that initiated event resulting in death)	onditions, mmediate erfying r injury	b. Pul to (or as Due to (or as d.	a conseque	nce of):	y AR.			9 ± 18		
tte has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was deceder in the past 12 1 Yes 2 9 Unknown	2 months? □ No	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal de	eath 3	Ectopic pregna Other (specify			23	3d. Date of deliment	very Day Year
been signed by should be detac	by	11	, a	ontributing to death t		-	, ,			tobacco us		the cause of death
	Completed	Leftu	put su	d Righ	+ PA	tella			24a. Wa - aut per	is an opsy formed?	24b. Were aut prior to c death? 1 \( \text{Yes}	opsy findings avail ompletion of cause 2 \( \text{No} \)
ath. rr: After this certificate te funeral director, pag	ation; To Be	25. Was case refe examiner?  1 Yes 2 2  27. Manner of Dea  1 Natural 2 Accident	No	Hospital: 1 Inpati		NOutpatier 8b. Time o' Injury	28c. I	Other	g Home 5 Re 28d. Describe	sidence 6		ify)
within 24 hours after death. <b>To the Funerel Director: After</b> completely filled in by the fune	Certification;	3 Suicide 4 Homicide	6 Could not be determined	28e. Place of In	jury - At hom tc. (Specify)	e, farm, str	eet, factory, off.	ce		(Street and own, State)	Number or Ru	ral Route Number,
within 24 hours af  To the Funerel D  completely filled is	edicai	29a. Certifier (Check only one)	1 Certifying Ph 2 Medical Exan	ysician: To the best niner: On the basis of and manner st	of examination	edge, deatl n and/or in	n occurred at the vestigation, in n	e time, date and pla ny opinion, death oc	ice, and due to the courred at the time	e cause(s) a e, date and p	and manner as place, and due	stated. to the cause(s)
withis To th	Me	29b. Signature and	aune	al & n	1.1.		0	ense number 235+5	<b>&gt;</b>		signed (Month	
		30. Namerand add	ress of person who	Th. H.I)	death (Item 2	3a) (Type,	Print) Street	+ CHEST	utseen	. Vu	d 216	20
C+	ate	31. Date filed (Mor	nin, Day, rear)	32. Region 2005	ars Signatui	0	A. M.			1		

State Registrar DHMH 17 Rev 1/2001

			1 - For State Registrar	State of M	laryland / De <i>C</i>	partment ertificate			ınd Mentai		ene 0	05	140	)   6
I	Physici		1. Decedent's Name (First, Middle, L William G	<sub>ası)</sub> eorge Adam	s Jr.				2. Date Mont Apr	of Death th i1	Day 22.	2005	3. Time of 7:35	Death 5 PM
	/Medio Examin		4a. Facility Name (If not institution, g 1233 Carroll St	reet		В	alti	Location of	f Death			ty of Death		
	Funeral Director		5. Social Security Number 6. 214-86-9831  Usual Residence of Decedent	Sex 7. A 1 M 2 □ F	ge (In yrs. last birthda 30 Yrs	Months	Days	Hours	Min. 8. Date (Mon Aug	of Birth th, Day, Y	1974	9. Birthpla Count Mary	ace (State o ov) Land	r Foreign
	72 hours after death with the Maryland natural', or Items 23s or 28s-f show lical Examination by molfied at	Director	10a. State 10b. County  Maryland N/A  10e. Street and Number  1233 Carroll S	tract	10c. City, Town of Bal	imore 10f. Zip (				10g	ı. Citizen o	f What Count	od. Inside Ci 1X Yes ry?	•
900	ours after death v ral', or itams 23a Examinar muni	by Funeral	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Deceden Armed Forces	? !No	3. Was Decede	fy Cuban	panic Orig , Mexican, Specify:	gin? (Specify Yes , Puerto Rican, el	or No-	ВІ	USA ace - America ack, White, e ify: Whi	itc.	
21215-0036	1 within jiene. r than "	Completed	15. Decedent's (Specify only highest s Elementary/Secondary (0-12)		5+) (G	cedent's Usual ive kind of work a. DO NOT use ever Wo	k done du e retired)	tion uring most	of working	16	b. Kind of $ m N$	Business/Ind	ustry	_
Maryland	should be filed and Mental Hygid marked other umatic event, II	To Be C	17. Father's Name (First, Middle, La William George A	dams Sr.				Tε	r's Name <i>(First, M</i> ammy Mor	sell_				
	s 1 and 2 should f Health and Mer item 27 is marke other traumatic		19a. Informant's Name/Relationship William George A			-			ror <i>Rural Route i</i> : Baltimo					
Baltimore,	0 0		20a. Method of Disposition  1  Burial 2 Cremation 3  4  Donation 5 Other (Special Control of the	☐Removal from State	20b. Place of Di	sposition (Namerematory or ott	e of her place	)	Date 04/25/05	20	c. Location	nore, N	vn, State	and
Balt	permit. Pag Depertment Important: I any Injury o		21. Signature of Funeral Service Lie Thomas Grego	Dun		Cremat 299 Fr	i Address ion eder	Societick F	ty Of M. Road Bal	aryla timor	ind Ir	nc. aryland	1 2122	28
STATE STATE OF	Pnysician /Medical Examiner	76	23a. Part1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions.	a. Non- Due to (or a	ad the death. Do not line.  HadelCs. s a consequence of): s a consequence of):	enter the mode		how		tory arrest	t,	5	Approximate Interval Betto Onset and I	ween
8760,	death certificate be executed e attending physician and of for use as the burial-transit	dical Examine	Sequentially list conditions, if any, leading to immediate cause. Litter Underlying Cause (Disease or injury that initiated events resulting in death) Last	с.	s a consequence of):									
.O. Box 6	that the death certifica led by the attending ph detached for use as t	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		e of pregnancy 2 □ Fetal death at time of death	3 □Ectopic pre 5 □ Other (spe						ate of deliver	,	Year
ords, P	The law requires that the ste has been signed by the bage 2 should be detache	by	Part II. Other significant conditions	contributing to death	but not resulting in th	e underlying ca	use giver	n in Part I.	23e		cco use co 2 🗆 No	ntribute to the	e cause of d ably 4 □L	
al Record		Completed							_   _	Was an autopsy performe		o. Were autop prior to com death? 1 ☐ Yes	pletion of ca	available ause of
Vital	Physician: this certific ral director,	o Be	25. Was case referred to medical examiner?  1  Yes 2 No	Hospital: 1 ☐ Inpat	ient 2 ☐ ER/Outpa	tient 3 DO	Othor		of Death (Check		ce 6 □O	ther (Specify	J	_
Division of	ing After une	atlon; T	27. Manner of Death  1 Natural 5 Pending investigat	28a. Date of In (Month, D	ury 28b. Tim	e of 28	Bc. Injury Work	at	28d. Des		injury occu	/-F//		
Divis	5 # 5 E	Certification;	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	28e. Place of li building, e	njury - At home, farm, etc. (Specify)	street, factory,	office		28f. Loca City	tion (Stree or Town, S	et and Nun State)	nber or Rural	Route Num.	ber,
	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	Medical	(Check only 2 Medical Ex	Physician: To the bes aminer: On the basis and manner s	of examination and/o	r investigation,		inion, deat		time, date	and place		the cause(s	)
/			· And	Leus	death (learning)	D	35	03	(		4/2	SIAT	-	
	Sta	ite	STEVEN (). 31. Date filed (Month, Day, Year)		death (Item 23a) (Ty 1650 trar's Signature	OZLEGA	2 2	r, B	Anno	ho-	MD	212	1 5	
Ni	Registr		AP	R 2 6 20 5	Description	N A	346	5.						

			Tor State Registrar		epartment of Health and Certificate of Death	Mental Hygie	1.000	14017
	°0		1. Decedent's Name (First, Middle, Last)			2. Date of Death	Day Year	3. Time of Death
	Physicia /Medic		MARUIN A	RION			15V 2005	2:40 A M
	Examin		4a. Facility Name (If not institution, give :	( )	4b. City, Town, or Location of Deat	h	4c. County of Death	
			5. Social Security Number 6. Sec	x 7. Age (In yrs. last birtho	day) If Under 1 Year   If Under 24 Hrs	O Date of Birth	DALTI	
н	Funeral Director			M 2 F Yr	Months Days Hours Min	(Month, Day, Ye		nplace (State or Foreign untry)
	ס		Usual Residence of Decedent			1-1-15	, VIV	ginia
	arylan show	_	10a. State 10b. County	10c. City, Town o	or Location			10d. Inside City Limits
	he M	Director		IORE	utherville			1 □ Yes 2 No
	with t		10e. Street and Number	· Ila · Aai M	10f. Zip Code	10g.	Citizen of What Cou	intry?
	ns 23	Funeral	5 Nightingal	12. Was Decedent Ever in U.S.	13. Was Decedent of Hispanic Origin? (S	pecify Yes or No-	14. Race - Amer	rican Indian.
9	or Iter		1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 No If Yes, Give	<ol> <li>Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puen 1 Yes 2 No Specify:</li> </ol>	to Rican, etc.)	Black, White	1 1 1
93	ural',	d by	3 Widowed 4 □ Divorced	Year or Dates:	1 ☐ Yes 2 <b>ZN</b> No Specify:		Specify: W	か、た.
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or Items 23e or 28a-f show he Madical Exertitual F. ust be rediffed at	Completed	15. Decedent's Edu (Specify only highest grad	e completed) ((	ecedent's Usual Occupation Give kind of work done during most of wo ife. DO NOT use retired)	rking 16b	. Kind of Business/l	ndustry
12	within ene. than	dwc	Elementary/Secondary (0-12)	College (1-4or 5+)   ( ) i	ctronics Tester		Roadia	
	be filed within 72 hours after death with the Marylan ital Hygiene. Ind other than "naturel", or liems 23a or 28a-f show avant, the Medical Exercitive Frust be inclined at	Be Co	17. Father's Name (First, Middle, Last)	1		me (First, Middle, Maid	den Sumame)	
<u>lan</u>	should be nd Mental marked matic av	O B	William Mic	hael Arion	Ressie	1 Shi	noth	
Maryland	s 1 and 2 should f Health and Men itam 27 is marks othar traumatic		19a. Informant's Name/Relationship (Ty		Mailing Address (Street and Number or Re	ural Route Number, Oi	ty or Town, State, Z	ïp Code)
	and and m 27 m 27 rar tr		Melvin E. Beck	- Step-SON 220	19 Rosecroft B		shing ton	MD 20744
ore	0 0		20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐ F	Removal from State cemetery,	Disposition (Name of crematory or other place)		. Location City or	
Baltimore	t. Pactmentant:		4 □Donation 5 □ Other (Specify)	Dolaney	Valley Mem. Gardens 4-	25.05 T	i MODIUM.	mD
Bal	permit. Pag Department Important: any injury c		21. Signature of Funeral Service Licens	30)	22. N me and Address of Facility PEACEFUL ALTERNATI	D. TIMONIC	m m D 21	093
			23a Part 1 Enter the disease or comple	icalines that caused the death. Do no	HEHCEFUL HLTERNATI	VES FUNERAL	CREMATIO	Approximate
			shock, or heart failure. List only or Immediate Cause (Final		t enter the mode of dying, such as cardia			Interval Between Onset and Death
	Prrysician / /Medical		disease or condition resulting in death)	Due to (or as a consequence of)		FAILURI	=	DAYS
ĕ	Examiner					12 EDJOE		years
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequence of)		7. 0		1000
	ocuted nd transi	Examiner	that initiated events	E LEVEN				years
90,	be executed ician and burial-transit	EX	resulting in death) Last	Due to (or as a consequence of)	):			
8760	icate be executed physician and s the burial-transit	dical		1				
9 X	the death certificate y the attending phys iched for use as the	lan/Me	IF FEMALE:	23c. If yes, outcome of pregnancy			23d. Date of deli-	
Вох	death atter	clar	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	1 Live birth 2 Fetal death 4 Pregnant at time of death	3 Ectopic pregnancy 5 Other (specify)		Month Month	Day Year
o.		Physicia	9 Unknown	9□ Unknown				
S,	The law requires that ate has been signed b age 2 should be deta	by P	Part II. Other significant conditions con	ntributing to death but not resulting in t	he underlying cause given in Part I.	23e. Did tobac	co use contribute to	the cause of death?
ord	w require been sig should b	led				1 ☐ Yes	2 □ No 3 □ Pro	obably 4. Unknown
Records,	law ras be	Completed				24a. Was an autopsy	24b. Were aut	topsy findings available completion of cause of
<u> </u>		Con				performed	<pre>1? death?</pre>	2 🗆 No
Vital	Physician: Th this certificate al director, pag	Be	25. Was case referred to medical examiner?	Hospital:	Out	ath Check onl one		
of	Phys this ral dii	2	1 Yes 2 No	1 ☐ Inpatient 2 ☐ ER/Outp  28a. Date of Injury 28b. Tin		dome 5 Residence		ity)
on	ding h. After funer	tlon	1 ■ Natural 5 □ Pending 2 □ Accident investigation	(Month, Day Year) Inju	ury Work? M 1 ☐ Yes 2 ☐ No	20d. Describe now r	njury occurred	
Division	al or Attanding after death. I Diractor: After d in by the fune	fica	3 Suicide 6 Could not be	28e. Place of Injury - At home, farm building, etc. (Specify)		28f. Location (Stree	t and Number or Ru	ral Route Number,
Ö	al or	Certification;	4  Homicide determined	building, etc. (Specify)		City or Town, S	ta te)	
	To the Hospital or within 24 hours after To the Funaral Diracempletely filled in b		29a. Certifier Certifying Phy (Check only 2 Medical Exami	sician: To the best of my knowledge,	death occurred at the time, date and place or investigation, in my opinion, death occurred.	e, and due to the cause	e(s) and manner as	stated.
	the H nin 24 the F nplete	Medical	one)	and manner stated.				```
	To To	~	29b. Signature and title of certifier	1.4.12	29c. License number	!	Date signed (Month	
,			A 13	MP	00053157	2 A	2R1L 27	ina 5002
	1		30. Name and address of person who co	2 H 32 27	DO 0 5 3 1 50 ype, Print)	A 10.	150 I A.	2120
	* Sta	te.	31. Date filed (Month, Day, Year)	32 Maistrar's Signature		100	UJUN, N	
.5	Registi		APR 2 6 21	005 Seem &	Soule			

			For State Registrar		State of	Marylar		artmen rtificat			and M		giene. Reg. No.	41111	5	14018
	Physici /Medic		1. Decedent's Name Catherin									2. Date of Dea Month 04	Day	2005	ar	3. Time of Death 02:00a M
	Examir		4a. Facility Name (If r 6204 We1	born Dr	•			Bet	heso					County of D		
	Funeral Director		5. Social Security Nur 487-52-0 Usual Residence of D	320	Sex 7. 1 ☐ M 2 ☐ F	Age (In yrs. 58	last birthday) Yrs.	If Under Months	1 Year Days	If Under: Hours	Min.	8. Date of Birt Month, Pa 03-07-	1 947	9. P	Birthplac Country enns	e (State or Foreign ylvania
	Maryland	tor		10b. County  Mont got	mery		ty, Town or Lo								10d.	Inside City Limits 1  Yes 2 □ No
	h with the 3a or 28a st be not	Funeral Director	10e. Street and Numb 6204 We1	born Dr	•			10f. Zip	Code	2081	6		10g. Citiz US.	en of What	t Country	?
036	72 hours after deeth with the Maryland netural; or Items 23s or 28s-f show iteal Ezand et must by mullied at	by	11. Marital Status 1 Never Married 3 Widowed 4		12. Was Decede Armed Force 1 Tyes 2 If Yes, Give Year or Date	es? ⊠No	ı	Was Deced f Yes, spec 1  Yes		spanic Ori n, Mexican Specify:	gin? (Spe i, Puerto I	cify Yes or No- Rican, etc.)		4. Race - A Black, V Specify:	Vhite, etc.	
1215-0	within 72 hou ene. than "neture tha Medical E	Completed			Education rade completed) College (1-4	or 5+)		dent's Usua kind of wo DO NOT us	rk done d se retired,	luring most )		ng		ence		cy Resear
Maryland 21215-0036	ould be filed Mental Hygi arked other etic svent, I	To Be Co	17. Father's Name (F	verett 1	pollock							(First, Middle, ine Eli:		,	nes	
Baltimore, Mar	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan Department of Health and Mental Hygiene.  Department of Health and Mental Hygiene.  Brownstant: If time Z1 is marked other than "netural, or Nems 23s or 28s-1 show any injury or other treumetic svent, It is Medical Examinat must be nullified at once.		19a. Informant's Nam Walter A:  20a. Method of Dispo 1 □ Burial 23© 1 ⁴ □ Donation 5	iles (hi sition Cremation 3	usband) □Removal from Sta			Welt	orn ne of ther place	Dr. I	Bethe	Poute Numbersda MD	208.		y or Town	State
Baltir	permit. P Departme Importan any injur		21. Signature of Fund	eral Service Lice	ann	M00382	2 R 9	. Name an app I 33 Gi	d Addres uner st A	s of Facilit a1 & ve Si	y Crem Llver	nation : Spring	Servi	ice		
	death certificate be executed  Water and Jacob Stream and Jacob Stream and Jacob Stream and Jacob Stream at the burial-transit	licai Examiner	23a. Part1. Enter the shock, or heart Immediate Cause (Fidisease or condition resulting in death)  Sequentially list condification from the sequentially list condification from the sequential form of the sequential form. Sequentially list conditions are suited to the sequential form of the sequential form. Sequentially list of the sequential forms are suited to the sequential forms of th	failure. List onlinal litions, lediate ying	a	as a consect as a consec	quence of):	er the mod	e or ayını	g, such as	cardiac o	r respiratory ar	rest,		Int	oproximate terval Batween nset and Death 1/2 year
	that the death certific led by the attending p detached for use as t	Physician/Medical	IF FEMALE: 23b. Was decedent p in the past 12 m 1 □ Yes 2 1 9 □ Unknown	onths?	23c. If yes, outco 1 ☐ Live birth 4 ☐ Pregnan 9 ☐ Unknow	n 2 ∏ Feta tat time of c	al death 3 🗆	Ectopic pr					2	3d. Date of Month	delivery Da	y Year
7	quires that in signed by	by	Part II. Other signific	ant conditions	contributing to deat	h but not res	sulting in the ur	nderlying c	ause give	n in Part I.		23e. Did to				ause of death?
Ĩ	: The law requires cate has been sign , page 2 should be	Completed		5-0-1								24a. Was autop perfor 1 Yes	sy	24b. Were prior death	to comple h?	findings available etion of cause of
ON OT VIG	ttsnding Physicien: Th death. stor: After this certificate t the funeral director, pag	tion: To Be	25. Was case referreexaminer? 1 ☐ Yes 2√√√√. 27. Manner of Death 1√√√√ atural 2 ☐ Accident			A STATE OF THE PARTY OF THE PAR	ER/Outpatien 28b. Time of Injury		8c. Injury Work	r: 4 🗆 Nu	rsing Hon	(Check only on the Market only one Market only on the	ence 6		Specify)	
DIVISION	tal or Attending rs after death. al Director: After ed in by the fune	Certification:	3 Suicide 4 Homicide	6 Could not determine	be 28e. Place of	Injury - At h	ome, farm, str	eet, factory				28f. Location (S City or Tow		Number o	r Rural Ro	oute Number,
	To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by	Medical	(Check only 2 one)	Medical Exa	hysician: To the be miner: On the basi and manner	s of examina	owledge, death ation and/or inv	estigation	in my op	inion, deal	d place, a th occurre	ed at the time, o	late and	place, and	due to the	e cause(s)
	with	2	29b. Signature and tit	alin	u Zu	yen	eli		MD00	52718	3		19d. Date	e signed (M	25	2005
	() Sta	to	Joanne Zu  31. Date filed (Month)	ijewski	6130 Exc	utive	Blvd.	Ste 7	025	Rocky	7i11e	MD 208				
	Registr	_	31. Date filed (Month	PR 26	2005	ر معلیٰ	ature A	arke								

			1 - For State Registrar	State of M	1arylan		artment rtificate			and Mo		giene Reg. No.	005	14019	)
	Physici		1. Decedent's Name (First, Middle, Las Robert D. Allan	")							2. Date of Dea	Day	Year	3. Time of Death	4
	/Medic Examir		4a. Facility Name (If not institution, give	street and number	r)		4b. City, T	Town, or	Location of	of Death	04	18 4c. 0	2005 County of Deat	7:20p	
			Holy Cross Hospi						Spri				Montgom		
	Funeral Director		5. Social Security Number 6. Se 577-46-7703	X 7.A ZM 2□F	ige (In yrs. 68	last birthday) Yrs.	If Under Months	Days	If Under: Hours	Min.	8. Date of Birt (Month, Day 07-10	h y, Year) _1034	9. Birth	nplace (State or Foreig untry) Ohio	רון
	D		Usual Residence of Decedent								07-10	-1930	,	OILLO	_
	arylar ahow	-	10a. State 10b. County MD Montgoi	norm		y, Town or Lo 1ver S								10d. Inside City Limits 1√2 Yes 2 □ No	
	the M	Director	10e. Street and Number	пету	31	TAGE S	10f. Zip					10g Citiz	en of What Co		_
	3a or	Ö	2024 Georgian Woo	ods Place	<u>:</u>		TOIL ZIP	0000	2090	2	:	US		and y :	
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importents: if item 27 is marked other than "natural", or items 23a or 28a-1 ahow any injury or other treumatic event, the Medical Examinar must be redified at ODGe.	by Funerai	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Deceder Armed Forces 1  Yes 2  If Yes, Give Year or Dates	? ] <b>N</b> o		Was Decede f Yes, speci 1 ☐ Yes 2		ispanic Ori n, Mexican Specity:	gin? (Spe i, Puerto F	cify Yes or No- Rican, etc.)		4. Race - Ame Black, White Specify: Wh	e, etc.	
2-0	72 ho	eted	15. Decedent's Edi (Specify only highest grad			16a. Deced	dent's Usual kind of work	Occupa	ation	of workin	a	16b. Kin	d of Business/	ndustry	_
121	vithin ne. han "	Completed	Elementary/Secondary (0-12)	College (1-4o	r 5+)	Reti	DO NOT use	e retired	)	or working	· ·		V		
0 7	filled v Hygie other t		17. Father's Name (First, Middle, Last)	2		Reci			18. Mothe	r's Name	(First, Middle,		Kno Sumame)	my	_
'lan	Aental Aental rked c	To Be	Robert Allan								a Alla		,		
lary	2 sho and N is ma		19a. Informant's Name/Relationship (7				-						Town, State, Z		_
e,	1 and 4ealth em 27 ther to		Ann C. Allan (with 20a. Method of Disposition	e)	20h F	2024 Place of Dispo	7.75		1 Wood		ace Si		Spring ation - City or	MD 20902	
nor	agas ant of it: if its y or o		1 ☐ Burial 2 € Cremation 3 ☐  4 ☐ Donation 5 ☐ Other (Specify			emetery, cren	natory or oti	her plac	e) ory		1-2005		eltsvil		
Baltimore,	permit. F Departme Importer any injur		21. Signature of Funeral Service Licent	999	M003	as 16 7	Rapp	Fune	eral 8	cre	mation	Serv	rice		
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	M unn	ed the deat		er the mode	ST of dyin	g, such as	cardiac or	r Sprii respiratory ar	ng ML rest,	20910	Approximate Interval Between	
	Physician		Immediate Cause (Final disease or condition			Heart	Failu	re						Onset and Death  Days	
	/Medical Examiner		resulting in death)	Due to (or a											
	0.40	ē	Sequentially list conditions, if any, leading to immediate cause. Litter Universiting Cause (Disease or injury	b. Liver										Years	
/	cutad nd ransit	Examiner	Cause (Disease or injury that initiated events	c. Coagul	opath	У								Days	
90,	icate be executad physician and s the burial-transit	i Ex	resulting in death) Last	Due to (or a	s a conseq	uence of):									
68760,	icate b physic s the b	dicai		d								-			
P.O. Box (	that the death certificate be executed ed by the attending physician and detached for use as the burial-transit	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcom 1 □ Live birth 4 □ Pregnant 9 □ Unknown	2 Feta	Ideath 3	Ectopic pre Other (spe					23	3d. Date of deli Month	very Day Year	
	sign sign d be	ed by Pt	Part II. Other significant conditions co	ntributing to death	but not res	ulting in the u	nderlying ca	use give	en in Part I.			obacco us		the cause of death?	1
of Vital Records,		Completed									24a. Was autop perfor			topsy findings available ompletion of cause of	3
/ita	ysicien: Th is certiticate director, pag	Be (	25. Was case referred to medical examiner?							of Death	(Check only o				
of	Phys ral di	- T	1 Yes 2 No  27. Manner of Death	Hospital: 1 🔀 Inpa 28a. Date of In		ER/Outpatien		Othe Bc. Injury	4 🗆 140		ne 5 ☐ Resid 8d. Describe h		Other (Spec	ify)	
lon	ding Atte	tlon	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, E	lay Year)	Injury	M	Work	rat (? Yes 2. [∷]		ou. Describe i	iow injury	occurred		
Division	or A lifter Direction by	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of I building,	njury - At ho etc. <i>(Specif</i>	ome, farm, str	eet, factory,	office		2	8f. Location (S City or Tox		Number or Ru	ral Route Number,	
	To the Hospital or At within 24 hours after d To the Funerel Direct completely tilled in by	Medical (	29a. Certifier 1 Certifying Phy 2 Medicel Exem	sician: To the besiner: On the basis and manner:	of examina	wledge, death tion and/or inv	occurred a vestigation,	it the tim	ne, date an pinion, dea	d place, a th occurre	nd due to the o	cause(s) a	and manner as place, and due	stated. to the cause(s)	
	To the To the Comp	Σ	29b 515 alone and title of certifier	. 1 4 =	m	).			number				signed (Month		
			A.Na	- Erm			I	>5	698	7		4-	-19.	-02-	
	3		30. Name and address of person who of AHMED WAWA	2 mg	Po B	0 X S	Print) 38(	9	61a	ilh	ersh	ng	mo	20883	
	Sta Registr		31. Date filed (Month, Day, Year)  APR 2 6 2	005	trar's Signa	iture	ale					`	•		

# ARKUSZ EWSKI, ALBERT.

			For State Registrar	State of Marylar		irtment of F tificate of i		Mental Hy	giene) (	005	14020
	Physici	an	1. Decedent's Name (First, Middle, Last)	Albert Frank	Arkuss	zovaki S	'n	2. Date of De	eath Day	Year	3. Time of Death
	/Media	al	4a. Facility Name (If not institution, give	<del>-</del> -	AIRUSZ		r Location of Death	MAL	- 22 40 Cou	2005 nty of Death	2:20AM
	Examir	ier	North Arun	del Hospi	tal	Glen P	ournie		Ann	-	rundel
	. Funeral		5. Social Security Number 6. Sex	7. Age (Inlyrs.		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir	th	9. Birthp	place (State or Foreign
	Director		Usual Residence of Decedent	75	Yrs.			Sept.	26,1929	Mar	yľand
	yland yland		10a. State 10b. County	10c. Ci	ty, Town or Lo	cation				1	0d. Inside City Limits
	e Maria	ctor	Maryland Anne Arı	ındel l	Baltimo	re					1 ☐ Yes 2 <b>X</b> No
	or 28	Directo	10e. Street and Number			10f. Zip Code			10g. Citizen	of What Cour	ntry?
	eath w	erai	12 Second Avenu	e 12. Was Decedent Ever in U	12 12 1	212			U.S		an India
21215-0036	iges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hyglene.  If item 27 is marked other than "natural", or items 23a or 28a-1 show or other traumatic evant, the Medical Exart art must be rediffed at	by Funerai	11. Marital Status  1 Never Married 2 X Married  3 Widowed 4 Divorced	Amed Forces?  1 X Yes 2 No If Yes, Give Korea	11	Yes, specify Cuba	lispanic Origin? (Sp an, Mexican, Puerto Specify:	Rican, etc.)		Race - Americ Black, White, scify: Whi	etc.
5-0	72 ho	Completed by	15. Decedent's Edu (Specify only highest grade	cation	16a. Deced	ent's Usual Occup	ation	kina	16b. Kind o	f Business/In	dustry
121	within ene. than "	mple	Elementary/Secondary (0-12)	College (1-4or 5+)	1 -	NOT use retired rvisor	during most of work d)	,g	Ck_11	0:1 0	
	filed v Hygie othar t	ပိ	12th 17. Father's Name (First, Middle, Last)		bupe	1 1 1 5 0 1	18. Mother's Nam	e (First, Middle			ompany
Maryland	S should be filed within and Mental Hygiene. Is marked other then surmatic event, I'm M	To Be	Joseph	Arkuszewski			Cath	erine S	widers	ki	
lary	2 should and Men is marke		19a. Informant's Name/Relationship (Ty				and Number or Rui				
	tealth tealth tm 27 ther tr		Mary Arkuszewski			cond Aver		timore,			
Baltimore,	permit. Pages 1 and Department of Health Important: If itam 27 any injury or other ti once.		20a. Method of Disposition 1   Burial 2 □ Cremation 3 □ R	emoval from State	cemetery, crem	natory or other place	ce)			on - City or To	
ij	permit. Pag Department Important: I any injury o		* 4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service License			.1 Cemete	ry 4/25, ss of Facility Go				Maryland
Ä	permit. Departn Importe any inju		Karny In Zs	amirous	11 " 10	001 Ritch	ie Highwa	av Rolt	timoro		land 21225
J	hysician and we be executed by physician and by physician and as the burial-transit	ai Examiner	234. Part1. Enter the disease, or sompli shock, or heart failure. List only or immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consection of the consection).	uence of):	the stemp	ng Computation pulmon disea	meter	disco	2.se_	Approximate Interval Between Onset and Death
68760,	ificate g phys	edicai	0								
P.O. Box	The law requires that the death certif ate has been signed by the attending page 2 should be detached for use an	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d 9 ☐ Unknown	al death 3 🗌	Ectopic pregnancy Other (specify)	,			Date of delive Month	ery Day Year
	res that i	by Ph	Part II. Other significent conditions con	tributing to death but not res	ulting in the un	iderlying cause give	en in Part I.	23e. Did t	obacco use c	ontribute to th	ne cause of death?
ords	w require been sig should b	ed t						170	Yes 2□No	3 Prob	ably 4 Unknown
ecc	has be	Completed						24a. Was		b. Were auto	psy findings available mpletion of cause of
al H								perfo 1 ☐ Yes	ormed? 2 No	death?	2 No
of Vital Records,	Phyeician: The this certificate harral director, page	Be c	25. Was case referred to medical examiner?  1 Yes 2 No	ospital:	150/0	Oth	26. Place of Deat				
of	g Phye er this eral di	n: To	27. Manner of Death	28a. Date of Injury	ER/Outpatient 28b. Time of	28c. Injun	y at	ome 5 Resi			γ)
sior	utending I death. ctor: After y the funer	atio	1 Natural 5 Pending investigation	(Month, Day Year)	Injury	M 1 []	K? Yes 2□No				
Division	al or Attences after death	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Special	ome, farm, stre fy)	eet, factory, office		28f. Location ( City or To	Street and Nu wn, State)	mber or Rura	il Route Number,
	To the Hospital or Attending Phwithin 24 hours atter death. To the Funeral Director: After th completely filled in by the funeral	Medical (	29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Examin	sician: To the best of my knower: On the basis of examination and manner stated.	owledge, death ation and/or inv	occurred at the timestigation, in my of	ne, date and place, pinion, death occur	and due to the red at the time,	cause(s) and date and plac	manner as si ce, and due to	tated.  the cause(s)
	To the h within 24 To the f	Σ	29b. Signature and title of certifier			29c. License	e number		29d. Date sig	ned (Month,	Day, Year)
•	, ,		Math	^	10	D43	3977		iprel	22	2005
	10+1	111	30 Name and address of person who co	mpleted cause of death (Iter	7 23a) (Type, F	Print) 1 Druge	è Cilo.	Bris-	0a -0 -	mr.	0 10/-1
	Sta	te	31. Date Med (Month, Day, Year)	32 Registrar's Signa	ature)	1	- Court		run.	· + 11)'	21001.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/2001

Registrar

APR 2 6 2005

			1 - For State Registrar	State of Marylan	d / Depa		lealth and	Mental Hygi	ene 005	14021
	Physici		1. Decedent's Name (First, Middle, Last) Bjarne Andreasse	n				2. Date of Death	9, Day 2005 Year	3. Time of Death 9:05 A. M
	/Medic Examin		4a. Facility Name (If not institution, give s	treet and number)		4b. City, Town, o	r Location of Dea	th	4c. County of Dea	th
			Shady Grove Advent:			Rockvil1			Montgome	ry
	Funeral Director		5. Social Security Number  101-09-1685  Usual Residence of Decedent  6. Sex  1  □	7. Age (In yrs. 195)	Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min		Year) 9. Bir C Nor	thplace (State or Foreign ountry) 'Way
	Maryland of show	tor	10a. State 10b. County Maryland Montgome		th Pot					10d. Inside City Limits 1 ☐ Yes 2 No
	or 28	Directo	10e. Street and Number			10f. Zip Code		10	g. Citizen of What C	ountry?
	s 23a	rail	13624 Glenhurst Ro			20878			United St	
326	n 72 hours after death with the Maryland "neturel", or Items 23a or 28e-f show solical Exeminations to notified at	by Funerai	11. Marital Status  1 Never Married 2 Married  3 🖾 Widowed 4 Divorced	2. Was Decedent Ever in U. Armed Forces? 1 X Yes 2 No If Yes, Give Year or Dates: WW I		Was Decedent of H f Yes, specify Cuba 1 ☐ Yes 2 🎇 No		Specify Yes or No- to Rican, etc.)	14. Race - Am Black, Whi Specify: Wh	te, etc.
21215-0036	within 72 hou ene. than "neture he Medical E	Completed by	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	ation	16a. Deced (Give life.	dent's Usual Occup kind of work done DO NOT use retired	pation during most of wo d)	orking	Ship Dock	Industry
	be filed stal Hygi od other event.	To Be Col	17. Father's Name (First, Middle, Last) Nils Andreassen		Longs	shoreman		me (First, Middle, A	,	
Maryland	nd 2 shoulth and 27 is m	Ĕ	19a. Informant's Name/Relationship (Type Alf L. Andreassen/	•					City or Town, State,	
Z.	of Health of Health litem 27		20a. Method of Disposition	20b. P		sition (Name of natory or other place			20c. Location - City of	
Ĕ	nit. Pages vartment of ortent: If it injury or o		1 XBurial 2 □ Cremation 3 □ Re  '4 □ Donation 5 □ Other (Specify)		en-Wood	l Cemeter	у 200	5 E	Brooklyn,	
Baltimore,	permit. Pag Department Importent: any injury o		21. Signature of Funeral Service License	M0135	3 Ro	Name and Address ockville, ockville,	ss of Facility Ro Inc. 30 Marylan	bert A. I O West Mo d 20850-2	umphrey Fontgomery 2805	uneral Home/ Avenue
	Physician /Medical		23a. Part1. Enter the disease, or complice shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	e cause on each line.	eps'	er the mode of dyir	ng, such as cardia	c or respiratory arre	est,	Approximate Interval Between Onset and Death
E	Examiner	e.	Sequentially list conditions, if any, leading to immediate	Due to (or as a sinseq	ulu	onic				2 weeks
	ate be executed hysician and he burial-transit	Examiner	cause. Enter Underlying Cause (Unsease or injury that initiated events resulting in death) Last	Due to (or as a conseq	estru	e te	Rour	failer	16	Uss.
68760	ificate be g physiciar as the buri	icai	٥							
O. Box	at the death certificate be executed by the attending physician and Itached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregna 1 Live birth 2 Feta 4 Pregnant at time of d 9 Unknown	Ideath 3	Ectopic pregnanc Other (s <i>pecify)</i>	<b>y</b>		23d. Date of de Month	blivery Day Year
ecords, P	The law requires that the the bas been signed by the bage 2 should be detache	by	Part II. Other significant conditions con	tributing to death but not res	ulting in the u	nderlying cause giv	ven in Part I.			o the cause of death?
Υ.		Completed						24a. Was as autops perform	y prior to ned? death?	utopsy findings available completion of cause of
Vital	Physicien: Th r this certificate ral director, pag	Be	25. Was case referred to medical examiner?	ospital: 1		Ott	or	ath (Check only on	-,	
ö	ling After fune	tion: To	1 Yes 2 No   27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	ospital: Inpatient 2 28a. ate of Injury (Month, Day Year)	28b. Time of Injury	f 28c. Injui	v at		nce 6 □Other (Spow injury occurred	ecify)
Division	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At he building, etc. (Specification)	ome, farm, str	eet, factory, office		28f. Location (St. City or Town	reet and Number or F 1, State)	iural Route Number,
	the Hospi	Medical	one) /2   Medical Examin	ician: To the best of my kno ner: On the basis of examina and manner stated.	wledge, deat tion and/or in	h occurred at the ti vestigation, in my o	me, date and plac opinion, death occ	e, and due to the ca curred at the time, da	ause(s) and manner a ate and place, and du	s stated. e to the cause(s)
	To To	2	29b. Signature and title of certifier	00. 00	7	29c. Licens	se number	29	9d. Date signed (Mon	th, Day, Year)
	1121		men	elle	y n	11 D	582E	) 1	April	17 2002
	411		30. Name and address of person who co	mpleted cause of death (Iten  ATT  32. Registrar's Sign	Ad	2401		vch BL	vi) Suet	Rockille
	Sta Registi			2 6 2005	คลิงเล	M Soan	le			011

		•	For State Registrar	State of Ma	aryland / Depa <i>Cei</i>	artment of H			ene 0 0 5	14022
			Decedent's Name (First, Middle, La	st)				2. Date of Death		3. Time of Death
	Physicia			ngus Neil	Alemower			April 1	Day Yea 4. 2005	9:00P M
	/Medic Examin		4a. Facility Name (If not institution, giv		AISMEYEL	4b. City, Town, or	Location of Death	<b>F</b>	4c. County of De	
	Examin	el.	8905 Maxwell Dri			Potomac			Montgome	ery
	Funeral		5. Social Security Number 6. S	ex 7. Ag	e (In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	9. B	irthplace (State or Foreign Country)
	Director		215-72-8810	MM 2□F	47 Yrs.	Wichins Days	riodis iniii.	March 17	, 1958	Fĺorida
	De ,		Usual Residence of Decedent		10c. City, Town or Lo	ocation				10d. Inside City Limits
	arylar show	_	10a. State 10b. County		100. Oily, 10will of Ec	ocation				1 ☐ Yes 21 No
	Ba-f	Director		gomery		104 7i- Codo	Potomac	10	g. Citizen of What	Country?
	vith th	5	10e. Street and Number			10f. Zip Code		10		,
	s 236	ral		vell Drive	Ever in II S 13	Was Decedent of H	20854	ecify Yes or No-		ed States nerican Indian,
	ltem Item	Funeral	11. Marital Status  1 □ Never Married 2X Married	Armed Forces?		Was Decedent of H If Yes, specify Cuba	in, Mexican, Puerto	Rican, etc.)	Black, Wi	nite, etc.
5	72 hours after death with the Maryland Instural, or Items 23a or 28a-f show Jical Extraitment be notified at	by F	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2X No	Specify:		Specify:	White
200-	2 hou		15. Decedent's E	ducation	16a. Dece	dent's Usual Occup	ation		6b. Kind of Busines	
<u>.</u>	nin 77	ple	(Specify only highest grant (0.12)	College (1-4or 5	life.	kind of work done of DO NOT use retired	duning most of word d)	(III)		
7	d with	Completed	Elementary/Secondary (S-12)	5+		Food Tec	hnologist			onsulting
aud	othe vent,	0	17. Father's Name (First, Middle, Last	)			18. Mother's Nam	ie (First, Middle, M	laiden Sumame)	
ā	Aenta Aenta riked	To B	Richa	ard H. Als	meyer			Hele	n Hilemn	
<u>a</u>	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-1 show any injury or other traumatic event, Ira Macles Extrainer mast be notified at ance.		19a. Informant's Name/Relationship (	Туре, Print)	19b. Maili	ng Address (Street	and Number or Ru	ral Route Number,	City or Town, State	, Zip Code)
Ξ	and 2		Richard H. Alsmey	yer/ Fathe					Marylano	
e e	of He		20a. Method of Disposition  1 Burial 2 X Cremation 3		20b. Place of Dispo cemetery, cre	matory or other plac	ce)		20c. Location - City	or Town, State
E	Page nent int: If		' 4 □ Donation 5 □ Other (Speci	fy)	Montgom Cremato	riim Inc	Apr:	$\frac{11}{2005}$	Bethesda	, Maryland
7a11	permit. Departminents imports any injuice.		21. Signature of Fune al Service Lice	nsee	2	2. Name and Addre	ss of Facility Rol	pert A. P	umphrey	Funeral Home/ y Avenue
ñ	99 6 8 8		X Jems )		M00335	Rockville Rockville	, Marylan	nd 20850-	2805	Avenue
			23a. Part1. Enter the disease, or conshook, or heart failure. List only	plications that caused one cause on each li	the death. Do not en	ter the mode of dyir	ng, such as cardiac	or respiratory arre	est,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition		atic Pancr	eatic Car	cinoma			Onset and Death 8 Months
	/Medical		resulting in death)	a	a consequence of):	catic oar	CITOMA			o noncing
	Examiner		Conventially list conditions	b						
		ner	Sequentially list conditions, if any, leading to immediate outce. Enter Underlying Cause (Disease or injury	Due to (or as	a consequence of):					
	cutec	Examine	that initiated events	c						
Ď,	e exe ian a urial-t		resulting in death) Last	Due to (or as	a consequence of):					
9/8	death certificate be executed e attending physician and of for use as the burial-transit	dical		d	_					
و	leath certifica attending ph I for use as t	Med	IF FEMALE:							
ROX	ath ce itendi	Physician/Me	23b. Was decedent pregnant in the past 12 months?		2 Fetal death 3	Ectopic pregnanc	y		23d. Date of Month	delivery Day Year
o.	at the dea by the ai	SIC	1 Yes 2 No	4□ Pregnant a 9□ Unknown	t time of death 5	Other (specify)				
<u>۔</u>	requires that the teen signed by th hould be detache	Phy	Part II. Other significant conditions	contributing to death h	out not reculting in the	underhing cause an	ven in Part I	23e. Did tob	acco usa contribute	e to the cause of death?
ŝ	res #	by	Pai(II. Other significant conditions	contributing to death i	out not resulting at the	andonying occaso giv				Probably 4 Unknown
0.0	v require been si should I	ted								
ec	> LI 0	nple						24a. Was ar autops perform	y prior	autopsy findings available to completion of cause of
Vital Records,		Completed							No 1□	es 2□No
/#	Physician: r this certific ral director,	Be	25. Was case referred to medical examiner?	Hospital:		0#	100	ath (Check only one		
	Physi this c al din	2	1 ☐ Yes 2 💢 No	1 L Inpati		ent 3L DOA	4   Nursing P	lome 5 X Reside 28d. Describe ho	ence 6 Other (5	ipecify)
Ĕ		lon	27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	ay Year) 28b. Time Injury	Wo	rk? ]Yes 2□No	280. Describe no	w injury occurred	
S	tend Jeath tor: ,	cat	2 Accident investigation 3 Suicide 6 Could not	ho —	ium. At homo form o		163 20110	28f Location (St	reet and Number o	Rural Route Number,
Division of	or Attencafter death	Certification:	4 Homicide determine	building, e	jury - At home, farm, s tc. (Specify)	reet, factory, office		City or Town	, State)	
	pital urs a eral (		29a. Certifier 1 X Certifying P	hyginian. To the host	of my knowledge, dea	th occurred at the ti	me date and place	and due to the ca	ause(s) and manne	r as stated.
	Hospital 24 hours Funeral itely filled	Medical	(Check only one)	mysician: 10 the besi miner: On the basis of and manner s	of examination and/or i	nvestigation, in my	opinion, death occu	irred at the time, da	ate and place, and	due to the cause(s)
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Mec	29b. Signature and title of certifier	2112 1112111101 3		29c. Licen	se number	2:	9d. Date signed (M	onth, Day, Year)
	F 3 F 8		Alaik O	Mila man			D0000		,	15 0005
	1		30. Name and address of person who	neted cause of	death (Item 22a) (Tues	Print)	D23308		April	15, 2005
	10		1				00 2 1	1 M =	10m1 100	17 70/7
	C+	ate	Victor Priego, 1 31. Date filed (Month, Day, Year)	M.D. 6420 32. Regist	Rockledge :			sda, Mary	rand ZU8	1/-/04/
	Regist			2 6 200	Rossies A	· Sparts	)			
					ADV NEEDW	- V				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. U 1. Recedent's Name (First, Middle, Last) 2. Date of Death AMONTH 0905PM Physician 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death If Under 1 Year If Under 24 Hrs. Months Days Hours Examiner Anne Arundel North Arundel HUSPItal 8. Date of Birth Month, Day, Birthplace (State or Foreign Couply) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 12 M 2□F 238-18-1572 Director Usual Residence of Decedent death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State or other traumatic event, the Medical Examiner must be notified at Severn 1 ☐ Yes 2 760 Anne Arude Director 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 6 USA 8644 Pioneer 31144 Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Black 3 Widowed 4 Divorced "natural" 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

5700 WORKER 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other then "na any injury or other traumatic event, Ite Medic once. Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18 Mother's Name (First, Middle, Maiden Surname) Be BURNEY lliam 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Big 7726 Buck DR. Windson Mill, MD 21244 Wimbush daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State netro Crematory ⁴ 4 □ Donation 75 Other (Specify) 270 Fredhilton Fiss 22. Name and Address of Facility 21. Signature Funeral Service Licensee P. Murch Funeral Home P.A. Eatto. Mo 2123) Approximate Interval Between Onset and Death 23a. Plu1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of leart failure. List only one cause on each line. Immedi e fause (Final disease & condition resulting in death) **Physician** MIKUMOHIA /Medical Due to (or as a consequence of): Examiner ILEUS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): by Physician/Medical Examiner FIBK or Attending Physicien: The law requires that the death certificate be executed burial-transit ATZIAL Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, the attending physician the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 4 SUnknown 1 ☐ Yes 2 ☐ No 3 Probably Be Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No has completely filled in by the funeral director, page 2 a 1 ☐ Yes 2500 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Yes 2 ☐ No 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 ER/Outpatient 3 DOA Certification: To 1 Impatient this s after death. 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 1 Natural 5 Pending investigation 1 Tes 2 No 2 Accident 6 Could not be determined Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funerel I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 29c. License number

Registrar

State

Jer Bromie

2106

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2005

31. Date filed (Month, Day, Year)

APR 2 6

201

32. Registrar's Signature

			For State Registrar		State of Ma	iryland /		tment of H <i>ificate of l</i>				giene Reg. No.	005	14021	7
	Physici	an		e (First, Middle, Las							Date of Dea Month		Year	3. Time of Death	_
	Physici /Medio	cal	12 Facility Name (	Bur Bur	street and number)	175		4b. City, Town, or	r Longtion e	of Dooth		23	County of Deal		VI
	Examin	ner			ursing Hom	ne		Catonsv		or Death		40.		imore	
	uneral		5. Social Security N 166-18-7		ex 7. Age	(In yrs. last b		If Under 1 Year Months Days	If Under Hours	24 Hrs. 8. Min.	Date of Birth (Month, Day	Year)	9. Birt	hplace (State or Foreignator)	-
	irector		Usual Residence o	404		80	113.			Se	ept. 2	4,19	24 Pe	enńsylvania	1
arylan	a how	_	10a. State	10b. County		10c. City, Tox								10d. Inside City Limit	
the M	28a-f	recto	Maryland	Baltimor	e	G	atons	ville				10a Citiz	en of What Co	1 Tyes 2 N	
th with	23a or	al Di	6119 Nor	thdale Ro	ad				228				USA	,	
er dea	ltems Der ov	Funeral Director	11. Marital Status		12. Was Decedent E Armed Forces?		13. W	as Decedent of Hi res, specify Cuba	ispanic Ori	gin? (Specify n, Puerto Ric	y Yes or No- an, etc.)		4. Race - Ame Black, Whit		
urs aft	al', or	by	1 ☐ Never Marr 3 ☐ Widowed	ied 2X Married 4 □ Divorced	Amed Forces? 1 X Yes 2 □ N If Yes, Give Year or Dates:	1946	1 [	☐ Yes 2M No	Specify:				Specify: Whi	.te	
III C I C I C I S-0050 be filed within 72 hours after death with the Maryland	ingent and wenter typers.  It is marked other than "natural", or flems 23a or 28a-f show other traumatic event, the Modical Examiner must be multiled at	Completed	(Spec	15. Decedent's Ed	lucation de completed)	166	(Give ki	nt's Usual Occupa	during most	t of working		16b. Kin	nd of Business/	Industry	
withIn	than	dwc	Elementary/Seco	ondary (0-12)	College (1-4or 5			o NOT use retired nistrato:	•			Nı ı	rsing H	Jome	
be filled	other vent,	BeC	17. Father's Name	(First, Middle, Last)						er's Name (F	irst, Middle,			ione	
Mal ylailu 2 12 1 12 should be filed within band Mentel Hydiene	narke natic e	To		Burleigh		40					.a She				
and 2 sh	27 Is r r traur			ame/Relationship (1 Burleigh	•			Address (Street a							
es 1 a	f item r othe		20a. Method of Dis	position	Removal from State	20b. Place o	of Disposit	ion (Name of tory or other plac	ee)	Date			cation - City or		
t. Pages	rtant:		` 4 Donation	5 ☐ Other (Specify	)	Metro		atory In		04/25/				Maryland	
permit.	Important: If item 27 is any injury or other tra		10	meral Service Rigen Mc Sregory as Gregory	\$60		Cr 29	emation Freder	ss of Facilit SOC16 CLCK 1	ety Of koad B	Mary altimo	land	Inc. Marvla	nd 21228	
a H			23a. Part1. Enter t shock, or hea	he disease, or com int failure. List only	lications that caused one cause on each lin	the death. Do	not enter	the mode of dyin-	g, such as	cardiac or re	spiratory arr	est,		Approximate Interval Between	
	/sician ledical		Immediate Cause disease or condition resulting in death)		a long i	ass	Pe	-gut						Onset and Death	
	aminer				Due to (or as a	a consequence	of):							recipees	,
P	sit .	iner	Sequentially list co if any, leading to in cause. Enter Under cause Decage of that initiated events	inditions, nmediate orlying	Due to (or as a	consequence	of):							*	_
", execute	n and al-tran	Examiner	that initiated events resulting in death)	Last	c. Due to (or as a	ı consequence	of):								
ifficate be executed	physician and s the burial-transit	edicai E			d										
A OC	CD of		IF FEMALE:		23c. If yes, outcome of	of a roomana.						- 1			
The law requires that the death cert	o tte	Physician/M	23b. Was deceden in the past 12 1 \(\sum \text{Yes} \) 2 [	months?	1☐Live birth 3 4☐Pregnant at	2 Fetal deatl		ctopic pregnancy Other (specify)				23	3d. Date of del Month	Day Year	
at the	ed by the a detached t	hys	9 🗆 Unknown		9□ Unknown				-						
ires th	P 6	ρχ	Part II. Other signit	0.	ontributing to death but	t not resulting	in the und	erlying cause give	en in Part I.			baccous es 2□		the cause of death?	n
N requ	s been si	Completed	1 De roma	Pression	e bleda	0000	د ) م	4			24a. Was a	ın		topsy findings availabl	
The la	ate has page 2	Somp	Pros has	te can	www	Octo	Ge   O	7			autops perfori 1 Yes	med?	prior to death?	completion of cause of	
loian:	After this certificate he funeral director, page	Be	25. Was case refer examiner?	_	Hospital:			Otho			heck only or	10)			
P P	er this	n: To	1 Yes 2 2	110	28a. Date of Injur	y 28b.	Time of	3 DOA Other	4 Janvul		5 Reside		Other (Spec	cify)	
ending ath.	or: Aft	atio	1 ☑ Natural 2 ☐ Accident	5 Pending investigation		Year)	Injury		<br Yes 2 □ l	No					
or Att	Direct in by t	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Place of Inju building, etc	ry - At home, f . (Specify)	am, stree	t, factory, offica		28f.	Location (Si City or Town		Number or Ru	ral Route Number,	
Hospitel or Attending Physician:	To the Funeral Director:		29a. Certifier (Check only	12 Certifying Ph	ysician: To the best o	f my knowledg	e, death o	ccurred at the tim	ne, date and	d place, and	due to the c	ause(s) a	and manner as	stated.	
To the H	the Fu	Medical	one)		iner: On the basis of and manner stat	examination ai	nd/or inve			th occurred a					_
o F	<b>2</b> 0	2	29b. Signature and	title of certifler	)	0		29c. License					signed (Montl		
H	1		30. Name and addr	esselperson W	completed cause of de			int)	/	4		04.	24. 51	mforg 51001	
			Mc Cucel 31. Date filed (Mon	Jaens	2000	r's Signature	itcli	e High	my	508	3 Gleu	332	ing Ho	reford 5:001	
	Sta Registr		SI. Date filled (MON	APR 2	S 2005 ► 60	i s signature	de A	e service	U						

				1 - For State of Maryland / Del	partment of F		ntal Hygie	211115	14025
		Physic	an	Decedent's Name (First, Middle, Last)			. Date of Death Month	Day Year	3. Time of Death
		/Medi Examir	cal	John Robert Nelson Bolton  4a. Facility Name (If not institution, give street and number)	4b. City, Town, o	or Location of Death	April 6	23 2000 4c. County of Dea	
	1	LAdimi	161	Franklin Samare Hospital	Rosedo	ale	and the state of t	Baltin	more
		Funeral Director		5. Social Security Number $\begin{array}{c ccccccccccccccccccccccccccccccccccc$	Monthe   Dave	Hours Min.	Date of Birth (Month, Day, Ye Ay 15, 1	ear) 9. bir	thplace (State or Foreign ountry) nsylvania
		D		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or	Location		,, -		10d. Inside City Limits
		Maryla	ţō		dle River				1 ☐ Yes 2X No
		vith the	Funeral Directo	10e. Street and Number	10f. Zip Code		10g.	. Citizen of What Co	ountry?
		death v	erai	114 Dihedral Drive  11. Marital Status 12. Was Decedent Ever in U.S. 13	21220 3. Was Decedent of F	) Hispanic Origin? (Specif an, Mexican, Puerto Ric	y Yes or No-	USA 14. Race - Ame	
	36	s after , or ite		1 Never Married 2 Married 1 Never Married 2 No 1941	If Yes, specify Cub.  1 ☐ Yes 2 ☒ No		an, etc.)	Specify: Whi	
	2-00	2 hour	ted b	15. Decedent's Education 16a. Dec	cedent's Usual Occup	pation	168	b. Kind of Business	
5	121	within 7 ane. than "r	Completed by		lectrician	during most of working d)		Electric	ial
John	altimore, Maryland 21215-0036	perriit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "netural", or items 23a or 28e-f show any injury or other traumatic event, Ira Medical Exemicer must be notified at 2006.	Be Co	17. Father's Name (First, Middle, Last)	10001101an	18. Mother's Name (F			Lai
5	rylai	d Menti	To	John A. Bolton  19a. Informant's Name/Relationship (Type, Print)  19b. Ma	ilia a Addresa (Chara	Maude Br		T- 0-1	T. O. / l
Bolton,	Ma	and 2 sl ealth and n 27 is r				Drive Middl		,	•
70	ore,	ges 1 a t of Hea If item or othe		20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State  20b. Place of Discernetery, completely, completel	sposition (Name of rematory or other place	Ce) Date	200	c. Location - City or	Town, State
30	Itim	ii. Pa rtmen rtent: injury			cematory I			ltimore,	,
	B	permit. Departing Importe any inju-		Thomas Gregor	Cremation 299 Frede	ess of Facility Society Of Frick Road F	E Maryla Baltimor	nd Inc. e. Maryla	and 21228
_	Ī			23a. Part1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line.	enter the mode of dyir	ng, such as cardiac or re	espiratory arrest,		Approximate Interval Between Onset and Death
	1	Physician /Medical		disease or condition resulting in death)  a. Acute Vulmond  Due to (or as a consequence of):	ary Hem	ovrhage			40 minutes
		Examiner	<u></u>	if any, leading to immediate  Aspiration (Neu Du to (or as a consequence of):	unonia				odays
		cuted nd ransit	amine	causé. Enter Underlying Cause (Disease or injury that initiated events					
	8760,	ate be executed hysician and the burial-transit	icai Examiner	resulting in death) Last Due to (or as a consequence of):					
	687	tificate ig phys as Ihe		d					
	P.O. Box 6	The law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Med		3 Ectopic pregnancy	y		23d. Date of del	livery Day Year
	0	t the de by the a ached t	hysic	1 □ Yes 2 □ No 4 □ Pregnant at time of death 5 9 □ Unknown	5 ☐ Other (specify) _				,
	Is, F	w requires that the deben signed by the should be detached	by	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause giv	en in Part I.	23e. Did tobac		the cause of death?
	core	w requ	Completed				24a. Was an		
	l Re		Comp				autopsy performed	prior to death?	utopsy findings available completion of cause of
	Vita	sician: certific	o Be	25. Was case referred to medical examiner?  1 \( \text{Yes} = 2 \( \text{No} \) \( \text{Hospital:} \) 1 \( \text{Inpatient} \) 2 \( \text{ER/Outpatient} \)	ient 3□ DOA Oth	26. Place of Death (C ner: 4 ☐ Nursing Home			~ .
	n of	ng Phy fter this ineral d	-	27. Manner of Death 1 Adatural 5 Pending (Month, Day Year)	of 28c. injur	ry at 28d	d. Describe how i		ony)
	Division of Vital Records,	Attendi death. ctor: A y the fu	Certification:	2 Accident investigation		Yes 2 □No	Location (Stree	nt and Number or Ru	ural Route Number.
	Div	rs after al Dire	Certi	→ □ Hornicus building, etc. (Specify)			City or Town, S	State)	
		To the Hospitei or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director, it	edical	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, de 2 Medical Examiner: On the basis of examination and/or and manner stated.	eath occurred at the tir investigation, in my o	me, date and place, and opinion, death occurred	I due to the caus at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)
		To th within To th	Me	29b. Signature and title of certifier	29c. Licens	se number	29d.	Date signed (Monta	h. Day, Year)
	,	4/1	7	30. Name and address of person who completed cause of death (Item 23a) (Typ	LXXX	160453	Hp	11/25	2005
	16	)./		Dr. Anastasios Saliaris, 9000 Fr	aullin Squ	are Drive	Baltin	we MD	- 21237
		Sta Regista		31. Date filed (Month, Day, Year)  32. Registrar's Signature	M. Small				

Contribute of Death  Privation of Death					State of Ma						•	•	gible.	
A Purily having from from front controllance on numbers or numbers of numbe				1 - For Stete Registrar								711	05	14026
## A Sickle Bar Way    Control South Process   Control				LINDA KAY	BEL	L		T			Apr	15 2	200	9130 AM
Second		Examin	er											h
Table   Tabl				5. Social Security Number 6. Sec. 216–52–2805	7. Age			If Unde	r 1 Year If	Under 24 Hrs.	(Month, Da	h y, Year)	9. Birtl	
1   Security   1		land				10c. City,	Town or L	ocation						10d. Inside City Limits
1   Security   1		a-f sh	ctor	Md. Howard		Elli	.cott	City						1□Yes 2√∏No
The Second Program of the Company of		vith the	Dire					10f. Zij		_				untry?
The Second Program of the Company of		ns 238	eral		12. Was Decedent 8	ever in U.S	6. 13	. Was Dece			pecify Yes or No		Race - Ame	
Elementary/Secondary (0.12)   College (1-4or 5+)   HR Special ist   18. Mother's Name (First, Models, Mackets Summer)	030	ours after or ral, or Iter	by	1 ☐ Never Married 2X Married	1 ☐ Yes 2 🔀 N If Yes, Give	lo					Rican, etc.)			
Elementary/Secondary (0.12)   College (1.4or Se)   HR Special Sist Overment (5. Mother's Name (First, Mother, Marketine Starmer)   1.	- - -	"natur	letec	15. Decedent's Ed (Specify only highest grad	ucation de completed)		(Giv	e kind of w	ork done duri	n ng most of worl	king	16b. Kind of	Business/	Industry
Treative Name   First Mindle, Last)   The Market Name   First Name   American Name   The Mindle, Last)   The Name   Past Name   First Name	7	withir ene. than	dmo		<u> </u>				,			Gov	<i>r</i> ermer	nt
Wayne M. Phelps   Florence V. Curmings   Fl	פר	m - 0 2					<u> </u>	CC141		. Mother's Nam	ne (First, Middle,	Maiden Sum	name)	
Lawford Rusty Bell / Husband   200 Place of Desposition (Name of Disposition)   200 Place of Desposition)   200 Place of Desposition (Name of Disposition)   200 Place of Desposition)   200 Place of Desposition (Name of Disposition)   200 Place of Desposition)   200 Place of Desposition (Name of Disposition)   200 Place of Desposition)   200 Place of Desposition (Name of Disposition)   200 Place of Desposition)   200 Place of Desposition)   200 Place of Desposition (Name of Disposition)   200 Place of Desposition)   200 Place of Desposition   200 Place of Desp	Yiai		To									-		
The state of the s	Маг	d 2 sh th and th srr traum				d		_						
The state of the s	e,	s 1 an if Heal item 2 other	1			20b. Pla	ace of Disp	osition (Na	me of					
22a Part Lifer the glasses, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Immediate Cause (Final disease or condition of the state of t	Ē	Page nent o ant: # ury or					ar Hi	.11 Ce	emetery		9/2005	Brookl	yn Pa	ark, Md.
22a Part Lifer the glasses, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Immediate Cause (Final disease or condition of the state of t	galt	Department mporturny injuries		21. Signature of Puneral Service Licen	D . D		2			***				
Shock or heart failure. List only one cause or each line.  Interval Bayesean in Middlical Examiner    Security   Program   Pro		40280	,	23a, Part1, Enter the disease, or comp	lications that caused	the death.	Do not e						Md.	Approximate
Sequential in Security   Sequential is conditions   Sequential is conditi		Dhysician		shock, or heart failure. List only of Immediate Cause (Final	one cause on each lir	10.								
Due to (or as a consequence of):  Due to		/Medical		resulting in death)				ic C	arcii	JUNSCO	lar 18	rieas	e	years
The standard of the standard o		Examiner	L	Sequentially list conditions,	b. Hype			n						Year
The standard of the standard o		nsit	mine	cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consoqu	onico orj.							·
State   Stat	Ď	an and rial-tra		resulting in death) Last	Due to (or as	a consequ	ence of):							
The state of the s	-	cate be	0		d									
The state of the s		certific ding p	/Me					33 5	200			23d.	Date of del	iverv
1   Yes   2   No   3   Probably   4   Unknown    24a. Was an autopsy findings available prior to completion of cause of death?  1   Yes   2   No   3   Probably   4   Unknown    24a. Was an autopsy performed?  1   Yes   2   No   3   Probably   4   Unknown    25. Was case referred to medical exampter?  1   Yes   2   No   3   Probably   4   Unknown    25. Was case referred to medical exampter?  1   Yes   2   No   3   Probably   4   Unknown    26. Place of Death (Check only one)  27. Manny of Death   1   Natural    28. Date of Injury   28b. Time of   Injury   Work?  28. Date of Injury   28c. Injury at   Work?    28. Date of Injury   28c. Injury at   Work?    28. Place of Death (Check only one)  28. Date of Injury   28c. Injury at   Work?    28. Date of Injury   28c. Injury at   Work?    28c. Injury at   Work?    28c. Injury at   Work?    28d. Describe how injury occurred  1   Yes   2   No    28d. Describe how injury occurred  28d. Location (Street and Number or Rural Route Number, one)  29a. Certifier   Operitying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29b. Signature and tile of certifier   29c. License number   29c. License n	j.	the death by the atter ached for u	nysiciar	in the past 12 months?	4☐Pregnant at									
State		quires that in signed t	by	Part II. Other significant conditions of	ontributing to death b	ut not resu	Iting in the	underlying	cause given i	n Part I.				
25. Was case referred to medical example?  26. Place of Death (Check only one)  27. Manny of Death  28. Place of Death (Check only one)  28. Time of Injury at Work?  29. Cartiller (Check only one)  28. Time of Injury at Work?  29. Location (Street and Number or Rural Route Number, City or Town, State)  29. Location (Street and Number or Rural Route Number, City or Town, State)  29. Location (Street and Number or Rural Route Number, City or Town, State)  29. Location (Street and Number or Rural Route Number, City or Town, State)  29. Location (Street and Number or Rural Route Number, City or Town, State)  29. Location (Street and Number or Rural Route Number, City or Town, State)  29. Location (Street and Number or Rural Route Number, City or	Heco	9 2	omplet								autor perfo	osy ormed?	prior to death?	completion of cause of
1	II a	cian: ertifica actor, p	0	exampler?						6. Place of Dea				
29a. Certifier (Check only one)  29a. Certifier (Check only one)  29a. Certifier (Check only one)  29b. Signature and tyle of certifier  29c. License number  29d. Date signed (Month, Day, Year)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  PATELICA TOYE, MM 4565 Hemlock Cone Way, Edit of the cause (Signature)  32 Accident (Street and Number or Rural Route Number, Edity or Town, State)  28f. Location (Street and Number or Rural Route Number, City or Town, State)  28f. Location (Street and Number or Rural Route Number, Edity or Town, State)  29a. Certifier (Check only one)  29a. Certifier (Check only one)  29b. Signature and tyle of certifier  29c. License number  29d. Date signed (Month, Day, Year)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  PATELICA TOYE, MM 4565 Hemlock Cone Way, Ellicated May 20042  State  31. Date filed (Month, Day, Year)  32 Aegistrar's Signature	0	Phys rthis ral dii		Tes 2 No	1   Inpatie		-		OA					cify)
29a. Certifier (Check only 29m details)  29b. Signature and title of certifier (Check only 29m details)  29c. License number (Month, Day, Year)  29d. Date signed (Month, Day, Year)	0	nding tth. r: After e fune	atlon	1 Natural 5 Pending	(Month, Da)	Year)						,,		
29a. Certifier (Check only 29m details)  29b. Signature and title of certifier (Check only 29m details)  29c. License number (Month, Day, Year)  29d. Date signed (Month, Day, Year)	DIVIS	al or Atters s after dea	Certifica	3 ☐ Suicide 6 ☐ Could not be	286. Place of Inju			treet, factor	ry, office		28f. Location (: City or Tou	Street and Nu wn, State)	mber or Au	ural Route Number,
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  PATRICE A. TOYE, MD 4565 Hemlock Cone Way, Elli what aty MD 71042  State 31. Date filed (Month, Day, Year)  32 degistrar's Signature		he Hospil n 24 hour he Funera		(Check only 2 Medical Exam	iner: On the basis of	examinati	vledge, dea ion and/or	ath occurred investigation	d at the time, n, in my opini	date and place on, death occu	, and due to the rred at the time,	cause(s) and date and plac	manner as ce, and due	s stated. e to the cause(s)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  PATRICE A. TOYE, MD 4565 Hemlock Cone Way, Elliph City MD 21042  State 31. Date filed (Month, Day, Year) 32 degistrar's Signature		Nothing the state of the state	ĮΣ	29b. Signature and file of certifier	/	Des	why							
PATRICE A. TOYE, MD 4565 Hemlock Cone Way, Elli oft City MD 21042  State 31. Date filed (Month, Day, Year) 32 Megistrar's Signature	١	0		latyu A	ye M	-O <sub>V</sub>	VE'		1314	73		Apri	118.	2005
Sale 31. Date filed (Montal, Day, 1 bar)	1	1		PATRICE A. TOYE	um 4565	Hew	lock	Print)	Nau I	Fligh	aty M	0210	42	
		Sta Regist		31. Date filed (Morter, Day, 1 bar)	32 Tiogisti	ar's Signat	ure	hack	7					

		1 - For Amend Item Stata Ragistrar  1. Decedent's Name (First, Middle	, Last)	Cer	tificate of D	eaur	2. Date of De	Reg. No.		3. Time of Death
Physici			Edward Brown,	Sr.			April	22, Day 200	5 <sup>Year</sup>	2:10 P M
/Media		4a. Fecility Name (If not institution	, give street and number)		4b. City, Town, or L	_			y of Death	
-,		7800 block Ritc	<u> </u>	- 4 6 - 44 - 1	Glen Bu	rnie If Under 24 Hrs.	o Data d Dist		Arur	
Funeral Director		5. Social Security Number 216-76-2657  Usuel Residence of Decedent	6. Sex 1 XM 2 ☐ F 7. Age (In yrs. Ias 47	Yrs.	Months Days	Hours Min.	8. Date of Birt (Month, Da MAY 17	y, Year) 1957	Mary	place (State or Foreigntry) Land
28e-f ehow	tor	10a. State 10b. County Maryland Anne A		Town or Lo	Glen Bu	ırnie			1	0d. Inside City Limits
or 286	Directo	10e. Street and Number			10f. Zip Code			10g. Citizen of	What Cou	ntry?
23e d	ralD	1723 Saunders V	Vay		21061			USA	1	
teme factor	Funeral	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	. 13. V	Vas Decedent of His Yes, specify Cuban	panic Origin? (Spe , Mexican, Puerto	cify Yes or No Rican, etc.)	- 14. Ra Bla	ce - Americk, White,	
n of health and Mental rygene.  If item 27 Is marked other then "naturel", or iteme 23e or 28e-1 show or other treumatic event, the Madical Examinat must be notified at	by	1 Never Married 2 Marri 3 Widowed 4 Divorced	If Yes, Give Year or Dates:		☐ Yes 2XNo	Specify:		Speci		
"nati	lete	15. Decedent (Specify only highes		(Give	ent's Usual Occupat kind of work done du DO NOT use retired)	ion uring most of worki	ng	16b. Kind of E	Business/In	dustry
then the	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	Labor	,			Landso	anino	r
other ent, 1	Be Co	17. Father's Name (First, Middle, I	Last)	Labor		18. Mother's Name	(First, Middle,			
Menta irked itic e	To B	UNK. B	<sub>rown</sub> . Clarence Ga	11ion		Dorothy	Merson	n		
le ma euma		19a. Informant's Name/Relationsh			g Address (Street ar					Code)
m 27 her tr		Dorothy Peddico			Saunders					
t: If ite y or ot		20a. Method of Disposition 1 □ Burial 2 🂢 Cremation	3 □Removal from State cer	metery, cren	sition (Name of natory or other place,	)	ate	20c. Location		
rtent		* 4 ☐ Donation 5 ☐ Other (S <sub>k</sub> 21. Signate of Funeral Service			matory, I			Baltim	ore,	MD
Importent: If any injury or once.		Ellerm A. Ja	2.16	Ćr	Name and Address remation S 9 Frederi	ociety o	f MD, I	nc.	2122	0
		23a, Part1, Enter the disease, or	gorchik complications that caused the death.						<u> </u>	Approximate
sician :		Immediate Cause (Final	only one cause on each line.  Perforation of	f Du-	donal III.a.					Interval Between Onset and Death
edical		disease or condition resulting in death)	Due to (or as a conseque		deliar orce	er			-	
miner		Sequentially list conditions.	b							
sit	xamlner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury	Due to (or as a conseque	ence of):						
-tran	хап	that initiated events resulting in death) Last	c Due to (or as a conseque	ence of):						
	E E									
burial	0		0.				-			
he buria	ed							23d D	ate of delive	ary Day Year
anding p	yslclan/Medl	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregnand 1 Live birth 2 Fetal of 4 Pregnant at time of dea	death 3	Ectopic pregnancy Other (specify)				onth	
gned by the attending p be detached for use as	ed by Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	1 Live birth 2 Fetal of 4 Pregnant at time of dea	death 3	Other (specify)	n in Part I.	23e. Did to	obacco use cor	onth	ne cause of death?
is been signed by the attending p 2 should be detached for use as	by	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	1 Live birth 2 Fetal of 4 Pregnant at time of dea	death 3	Other (specify)	n in Part I.	1 🗆 Vas	obacco use cor res 20 No an 24b.	onth  atribute to the street of the street o	psy findings available
is been signed by the attending p 2 should be detached for use as	Completed by	23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown  Part II. Other significant condition  25. Was case referred to medical	1 Live birth 2 Fetal of 4 Pregnant at time of dea	death 3	Other (specify)	n in Part I.	24a. Was autor perio 1 Pes	obacco use cor res 20 No an 24b. orwed? 2 No	onth  tribute to the second of	ably 4 □Unknown
is certificate has been signed by the attending p director, page 2 should be detached for use as	Be Completed by	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  Part II. Other significant condition	1 Live birth 2 Fetal of 4 Pregnant at time of dea 9 Unknown	death 3	Other (specify)	26. Place of Death	24a. Was autor perio	obacco use cor res 2000 No an 24b. ssy rmed? 2000 No	onth  tribute to the second of	psy findings available
is certificate has been signed by the attending p director, page 2 should be detached for use as	To Be Completed by	23b. Was decedent pregnant in the past 12 months?  1	1 Live birth 2 Fetal of 4 Pregnant at time of deal of the set of t	death 3 ☐ ath 5 ☐	other (specify)  iderlying cause giver  at 3 DOA  Other  28c. Injury a	26. Place of Death	24a. Was autor period 1 la res	obacco use cor res 2000 No an 24b. ssy rmed? 2000 No	onth  Itribute to the stribute	psy findings available mpletion of cause of 2 No
is certificate has been signed by the attending t director, page 2 should be detached for use as	To Be Completed by	23b. Was decedent pregnant in the past 12 months?  1	1 Live birth 2 Fetal of 4 Pregnant at time of dea 9 Unknown  Ins contributing to death but not result the second s	death 3 Lath 5 L	other (specify)  iderlying cause giver  3 □ DOA  28c. Injury a Work?  1 □ Ye	26. Place of Death  4 \( \text{Nursing Hor} \)  at  ss 2 \( \text{No} \)	24a. Was autor period of the second of the s	obacco use cor res 20 No an 24b. ssy rmed? 2 No one) dence 6 20 ocu	onth  Initial to the state of t	psy findings available mpletion of cause of 2 No
birector; After this certificate has been signed by the attending principle of the funeral director, page 2 should be detached for use as	To Be Completed by	23b. Was decedent pregnant in the past 12 months?  1	1	death 3 Lath 5 L	other (specify)  iderlying cause giver  3 □ DOA  28c. Injury a Work?  1 □ Ye	26. Place of Death  4 \( \text{Nursing Hor} \)  at  ss 2 \( \text{No} \)	24a. Was autor period of the second of the s	obacco use cor res 2 No an 24b. syy rmed? 2 No one) dence 6 SOt now injury occu	onth  Initial to the state of t	psy findings available mpletion of cause of 2 No
to be the service of the contilicate has been signed by the attending protector. After this certificate has been signed by the tuneral director, page 2 should be detached for use as	Certification; To Be Completed by	23b. Was decedent pregnant in the past 12 months?  1	1 Live birth 2 Fetal of 4 Pregnant at time of dea 9 Unknown  Ins contributing to death but not result the second s	P/Outpatien 28b. Time of Injury	other (specify)  derlying cause giver  a 3 DOA  28c. Injury a Work?  M 1 Ye  pet, factory, office	26. Place of Death  4 \( \text{Nursing Hor} \)  at  es 2 \( \text{No} \)  a, date and place, i	24a. Was autor porton of the set	Mobacco use cor fes 2NNo an 24b. ssy rmed? 2 □ No dence 6 200 now injury occu  Street and Num vn, State)	onth  tribute to the second of	psy findings available mpletion of cause of 2 No  No  Replace No  Replace No
pearn. ttor: Affer this certificate has been signed by the attending r the funeral director, page 2 should be delached for use as	To Be Completed by	23b. Was decedent pregnant in the past 12 months?  1	1	P/Outpatien 28b. Time of Injury	derlying cause giver  aderlying cause giver  aderlying cause giver  28c. Injury a Work?  M 1 7 Ye  29ct, factory, office	26. Place of Death  4 \( \text{Nursing Hor} \)  at  es 2 \( \text{No} \)  a, date and place, anion, death occurrence.	24a. Was autor porton of the control	obacco use corves 20 No an 24b. syrmed? 20 No dence 6 20 Othow injury occu Street and Num cause(s) and m date and place 29d. Date sign.	onth  3 Prot  Were auto prior to co death  Her (Specifiered  ber or Rura  anner as s and due to ad (Month,	psy findings available mpletion of cause of 2 No  No  A Scene  A Route Number,  Lated.  The cause(s)  Day, Year)
to be the service of the contilicate has been signed by the attending protector. After this certificate has been signed by the tuneral director, page 2 should be detached for use as	Certification; To Be Completed by	23b. Was decedent pregnant in the past 12 months?  1	1	R/Outpatien 28b. Time of Injury ne, farm, stre	other (specify)  derlying cause giver  addriving cause giver  28c. Injury a Work?  M 1 1 Ye  est, factory, office  coccurred at the time estigation, in my opin  29c. License  OCME	26. Place of Death  4 \( \text{Nursing Hor} \)  at  es 2 \( \text{No} \)  a, date and place, anion, death occurrence.	24a. Was autor porton of the control	obacco use cor  Yes 2 No  an 24b.  syy rmed? 2 No  dence 6 2 Oth  conow injury occu  Street and Num  vn, State)  cause(s) and madate and place	onth  3 Prot  Were auto prior to co death  Her (Specifiered  ber or Rura  anner as s and due to ad (Month,	psy findings available mpletion of cause of 2 No 2 No  No  A Scene  A Route Number,  tated. the cause(s)  Day, Year)

ORIGINAL

			1 - For State Registrar	State of Maryla		ment of Health and icate of Death	12.2	C U U U	14028
			Decedent's Name (First, Middle, Last)				2. Date of Death		3. Time of Death
	Physici /Medio		Bradley H	ugh I	3ostor	)	April 2	Day Year 2005	1:37 PM
	Examir		4a. Facility Name (If not institution, give		,	c. City, Town, or Location of De	ath	4c. County of Death	
				land Medical		Baltin Under 1 Year   If Under 24 H	nove	NA	
	Funeral Director		5. Social Security Number 6. Sex			onths Days Hours M		ar Soyni	ace (State or Foreign
	ס		Usual Residence of Decedent				740011-)1	D 1 /via	rylana
	arylar show	_	10a. State 10b. County	10c. 0	City, Town or Locati	Lousville		10	Od. Inside City Limits
	the M	Director	Maryland Baff	700	Co	Gorgalie	1.10-	Citizen - Charles - C	1 Pres 2 No
	filed within 72 hours atter death with the Maryland Hygiene. ther than "netural", or Items 23e or 28e-1 show that the Modical Examitre challed rediffied at	Ī	144 Winters L	ane		21228	Tog.	Citizen of What Count	_
	death	Funeral	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S. 13. Was	Decedent of Hispanic Origin? es, specify Cuban, Mexican, Pu	(Specify Yes or No-	14. Race - America	
36	or Ite	by Fu	1 Never Married 2 Married	1 ☐ Yes 2 No If Yes, Give		Yes 21 No Specify:	ano mean, etc.)	Black, White, &	·V
Ö	hours tural'	ed b	3 ☐ Widowed 4 ☑ Divorced	Year or Dates:	16a Decedent	's Usual Occupation	100	. Kind of Business/Ind	4
21215-0036	nin 72 in "ne	plet	(Specify only highest grade Elementary/Secondary (0-12)		(Give kind	d of work done during most of v NOT use retired)	rorking		ustry
	giene giene er tha	Completed	12th Grade	College (1-401 37)		Disabled		MIT	
Maryland	be file ital Hy od oth event	Be	17. Father's Name (First Middle, Last)			18. Mother's N	ame (First, Middle, Maid	en Sumame)	
<u> </u>	should be nd Mental marked c	ဥ	19a. Informant's Name/Relationship (Ty)	ne Print)	10b Mailing A	ddress (Street and Number or	Bural Bouta Number Ci	huas Taum Stata Zin	Codel
	permit. Pages 1 and 2 should be filed within 72 hours atter death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "netural", or Items 23e or 28e f show any injury or other traumatic event, the Macical Examilitational Language. Once.		Leslie Cuba-s	. 1	79107	Pipers Path	Aon Bur	vie Man	land 2106
altimore,	of Hear item	1	20a. Method of Disposition	20b.	Place of Disposition	on (Name of	Date 20c	Location - City or T	n, State
Ē	permit. Pages Department of Importent: If it any injury or o	i	1 ☐ Burial 2 🗹 Cremation 3 ☐ R  `4 ☐ Donation 5 ☐ Other (Specify)	amoval from State	etro Cre	matory Ap	1130,2005 C	atonsville	Maryland
Balt	Departi Departi Import any inj once.		21. Signature of Funeral Service License	ie V.	22. Na	ame and Ad Jess of Facility	arkin Fun	val Home;	PA 2122
	70 = e d		23a. Part1. Enter the disease, or compli	actions that sourced the de	351	2 Frederick	Are Balti	more, Mar	yland
i			shock, or heart failure. List only on	e cause on each line.	atii. Do not enter ti	te mode of dying, such as card	ac or respiratory arrest,		proximate Interval Between Onset and Death
	Medical Examiner		disease or condition resulting in death)	Due to (or as a conse	Sunence of):				
			Commented to the second state of	200 10 (0) 20 2 001101	5quairee 61/.				
20.0	TO Æ	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underfying  Due to (or as a consequence of):						
/	and -trans	Examiner	that initiated events cresulting in death) Last	Due to for an a const					
8760,	cate be executed physician and the burial-transit			Due to (or as a conse	equence or):				
	cate phy the	edical	d						
ŏ	h cert ending	In/M	230. Was decedent pregnant	3c. If yes, outcome of pregi 1 □ Live birth 2 □ Fe				23d. Date of deliver	у
P.O. Box	e deat he att	by Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at time of		opic pregnancy her (specify)		Month	Day Year
<u>Ч</u>	at the	Phy	9 Unknown				20. Didut		
ď,	signe d be d	d by	Part II. Other significant conditions con	Infacch o		lying cause given in Part I.		co use contribute to the	a <sup>1</sup>
Sor	v requ been shoul	Completed	11.40000	THOUGHT	, ,		-		
Re	he lav e has						24a. Was an autopsy performed	?   death?	sy findings available pletion of cause of
a	an: T titicat tor, pa	a	25. Was case referred to medical			26 Place of C	1 ✓ Yes 2 ☐ eath Check onlone	No 12Yes	2□ No
<u>=</u>	nysici nis cer direc	To B	examiner? 1 ☐ Yes 2 ☐ No H	ospital: 1 Inpatient 2[	☐ ER/Outpatient :	Othor	Home 5 ☐ Residence	6 □Other (Specify	
Division of Vital Records,	ng Ph	ou:	27. Manner of Death  1 Natural 5 Pending	njury occurred					
	tendi leath. tor: A the fu	catl	2 Accident investigation 3 Suicide 6 Could not be	Accident investigation M 1 Yes 2 No					
$\leq$	or At after of Direction by	Certification:	4 Homicide determined	28e. Place of Injury - At building, etc. (Spec	home, farm, street, cify)	factory, office	28f. Location (Street City or Town, St	and Number or Rural ate)	Route Number,
_	To the Hospital or Attending Physician: The law requires that the death certifi within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending completely tilled in by the funeral director, page 2 should be detached for use as		29a. Certifier Certifying Phys	ician: To the best of my ki	nowledge, death oc	curred at the time, date and pla	ce, and due to the cause	a(s) and manner as etc	ited.
	n 24 h	Medical	(Check only 2 Medical Examination)	ner: On the basis of examinand manner stated.	nation and/or invest	igation, in my opinion, death or	curred at the time, date	and place, and due to	the cause(s)
	To t To tl	Σ	29b. Signature and title of certifier			29c. License number	29d.	Date signed (Month, D	Pay, Year)
			I prica Hersh	enson		P18568	<u> </u>	m1 24.	2005
	Q		30. Name and address of person who co				VV 212	01	
	Sta	te.	31. Date filed (Month, Day, Year)	32. Digistrar's Sign		paltimore 1	MD 212	01	
	Registr		APR 2 6 201	5 Bearing	H Ana	Mr.			

			1 - For State Registrar	State of M	larylan		artmen rtificat					gier Reg. 1	2000	14030
	Dhysisi	an	1. Decedent's Name (First, Middle, La	st)							2. Date of De Month		ay Year	3. Time of Death
	Physici /Medi		Josephi			anger					April	21	2005	2:40 A
}	Examir	ner	4a. Facility Name (If not institution, gir		)				Location -	of Death		4	lc. County of Deat	
			3935 Bush Cour		20 /la um	last birthday)		Abine	gdon If Under	24 Hrs	8. Date of Bir	*6	Harfo	
	Funeral Director			Sex 7. A 1 □ M 2/€ F	79	Yrs.	Months	Days	Hours	Min.	(Month, Da	ıy, Yea	1925 Mas	hplace (State or Foreign untry) SSAChusetts
	land		10a. State 10b. County		10c. Cit	y, Town or Lo	ocation							10d. Inside City Limits
	Mary 1 sh	tor	Maryland Harford		Δŀ	oingdo	n							1 ☐ Yes 2 No
	72 hours after death with the Maryland natural', or Hems 23a or 28a-1 show dical Exactive trouble redified at	Funeral Director	10e. Street and Number		1 230	JII IGUO	10f. Zip	Code				10g. (	Citizen of What Co	untry?
	th wit	aiD	3935 Bush Cou	rt				21	009				USA	
	ems erm	Iner	11. Marital Status	12. Was Deceden Armed Forces		.S. 13.	Was Dece	dent of H	ispanic Or	igin? (Spe	cify Yes or No Rican, etc.)	)-	14. Race - Ame Black, Whit	
36	or It	y Fu	1 Never Married 2 Married	1 Tes 2 1	-		1 🔲 Yes		Specify:		,		Specify:	<b>5, 5.5</b> .
Ö	ural',	d by	3 ∰Widowed 4 □ Divorced	Year or Dates:		1Co Door		-1.0	-4:			4.01-		White
215-0036	"nat	Completed	15. Decedent's E (Specify only highest gr	ducation ade completed)		16a. Dece (Give	dents Usu kind of wo DO NOT u	ork done o	durina mas	st of worki	ng	160.	Kind of Business/	industry
212	within ene.	E G	Elementary/Secondary (0-12)	College (1-4or	5+)		Pack		7			E.	ood Proce	occina
	2 should be filed and Mental Hygi is marked other eumatic event, i	Be C	17. Father's Name (First, Middle, Las	)		Mear	Pack	mig	18. Moth	er's Name	(First, Middle			2551119
a	id be lental ked c	To B	Silvio (nmn)	Zinanni					Cam	mella	(nmn)	ו ו	Mizzoni	
Maryland	should and Men s marke umatic	-	19a. Informant's Name/Relationship			19b. Maili	ng Address	s (Street a					y or Town, State, 2	Zip Code)
	s 1 and 2 should be filed within 72 hours after death with the Marylan I Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23s or 28a-1 show other treumatic event, the Medical Exact are must be relified at		Sylvia C. Violet	te / Daugh	nter	393	5 Bus	h Co	urt,	Abin	gdon, I	1D :	21009	
Baltimore,	os 1 and 2 of Health of Item 27 i r other tre		20a. Method of Disposition 1 ☐ Burial 2 🖾 Cremation 3 [	Domewal from State	1 -	lace of Dispo	osition (Name	me of other plac	ce)	0	ate	20c.	Location - City or	Town, State
Ĕ	Pages nent of I ant: If Its ary or o		4 Donation 5 Other (Special			lltop :	Servi	ce C	orp.	4-22	-05	T	owson, Ma	ervland
at	permit. Pag Department Importent: I eny injury o		21. Signature of Funeral Service Lice	nsee	+						me, P.A		, , , , , , , , , , , , , , , , , , , ,	
<u> </u>	<b>5</b> 0 € 5 9		Hille I Flow	& Pen	1	_	1317	Coke	sbury	7 Roa	d, Abir	ngdo	on, Mary	Land 21009
			23a. Part1. Enter the disease, or con shock, and failure. List only	plications that cause one cause on each	ed to death	h. Do not en	ter the mod	de of dyin	g, such as	cardiac o	r respiratory a	rrest,	one of the second	Approximate Interval Between
	Physician	ш	Immediate Cause (Final disease or condition	PANC	REGIT	c Ca	v cez							Onset and Death
	/Medical		resulting in death)	Due to (or a			Mark Sec.							U
	Examiner	١. ا	Sequentially list conditions.	b. Emph	1	X								20 yrs
7	sit ad	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or a	conseq	uence of):								v
V	be executed ician and burial-transit	хап	that initiated events resulting in death) Last	c. Due to (or a	s a consequ	uence of):								
8760,	be executed sician and burial-transit			220 10 (0. 0.	o = 00.100q	00.700 0.75								
387	physicate sthe l	dic		_ d										
9 X	The law requires that the death certificate tie has been signed by the attending physoage 2 should be detached for use as the	Physician/Medical	IF FEMALE:	23c. If yes, outcom-	e of pregna	incy							23d. Date of del	iven
Вох	atter I for u	clar	23b. Was decedent pregnant in the past 12 months?	1 Live birth 4 Pregnant a	2 Feta	Ideath 3	□Ectopic p □ Other (s <sub>f</sub>		1				Month	Day Year
P.O.	that the de ed by the detached	ysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown										
σ.	res that igned b be deta	by PI	Part II. Other significant conditions	contributing to death	but not res	ulting in the u	ınderlying o	cause giv	en in Part	l.	23e. Did	obacc	o use contribute to	the cause of death?
rds	quires n sign	q p									1	es	2 □ No 3 □ Pr	obably 4 Unknown
Records,	s been s should	Completed									24a. Was		24b. Were au	utopsy findings available
Be	The la	E										psy ormed 2 12 1	death?	completion of cause of 2□ No
		0	25. Was case referred to medical						26 Plac	e of Death	1 Yes	-4	40 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	2 10
>	Physicien: this certificantal director,	To B	examiner?	Hospital:							ome 5  Residence 6  □Other (Specify)			cify)
			27. Manner of Death	28a. Date of Inj (Month, D		28b. Time o		28c. Injun Worl			28d. Describe how injury occurred			
<u>ō</u>	Attending Ph death. ctor: After th y the funeral	atio	1 Natural 5 Pending 2 Accident investigation		ay rour,	injury	М		Yes 2	No No				
Division	after deatl Director: In by the	tific	3 ☐ Suicide 6 ☐ Could not l 4 ☐ Homicide determined	286. Place of ir	njury - At ho	ome, farm, st	reet, factor	y, office		1	28f. Location ( City or To			ural Route Number,
Õ	Itel or A rs after el Direc led in by	Certification:		- January, C								, 5.0	·	
	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune	Medical	(Check only 2 Medical Exe	hysicien: To the bes miner: On the basis	of examina	wledge, deal	h occurred vestigation	at the tin	ne, date ar pinion, dea	nd place, a ath occurr	and due to the	cause date a	(s) and manner as	s stated.  to the cause(s)
	thin 2 the mplet	Med	one)	and manner s	stated.									
	2		200. Orginatoro arrowing or continot	// /			25		7 > <	/			L/31/A	, -u, rour
	1		flum ff	and feel	1	- 00 =	D.1.1	Di	5 5 2	1		7	1010	70
	12		29b. Signature and Attle of certifier  36. Name and address of person who  M. Auer Bacin, 91  31. Date filed (Month, Day, Year)	completed cause of	death (Item	n 23a) (Type,	Print)	11	P	a fat.	m 1		2/235	7
	Q1	ate	31. Date filed (Month, Day, Year)	<b>3.</b> Regis	tra/s Signa	ture A	177	17,	DK	11/1	MARKE			
	Regist		NDD 9 E 20	105 1000	0	. April								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? State Registrar amend item #5 PER FH C843 5965/1649 Pf Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Montl Day 7a 'onaway A M Pri /Medical 4a. Facility Name (If not institution, give street and number) CETT & 4b. City, Town, or Location of Death Examiner 4c. County of Death Maryland Medical Year If Under 24 Hrs.
Days Hours Min. 5 216 - S27 - 4201 If Under 1 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Funeral Birthplace (State or Foreign Country) Months 1 □ M 2 👿 F Days Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If Item 27 Is marked other than "natural", or Items 23a or 28a-1 show amy injury or other treumatic event, it is Medical Evantric from the Lottling and once. 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Baltimore Completed by Funeral Director 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Quban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 Des 2 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 Widowed 4 Divorced BIACK 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+)) ashier 17. Father's Name\_(First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Lewis Conanay lurner 19a. Informant's Name/Relations in Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lewis Conaway Battimore 20b. Place of Disposition (Malne of cametery, crematory or other pla 20. Location - City or Town, State Date alvery Memorial Cemetery ¹ 4 □ Donation 5 □ Other (Specify) Greene Funeral 21. Signature of Funeral Service Licensee 22. Name and Address of Famility Red Randallstown MD 21132 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Wel /Medical Due to (or as a consequence of): Examiner FILLTUC Leukemia TURED Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a constant nce of). Examiner To the Hospital or Attending Physicien: The law requires that the death certificate ba exacuted the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 Other (specify) Division of Vital Records, P.O. the detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably Completed 4 □Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No page 2 autopsy perform certificate 1□ Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 1 Tyes Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Ceath 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \ Homicide within 24 hours a

To the Funeral C

completely filled i Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number *P16493* 29d. Date signed (Month, Day, Year) address of person who completed cause of death (Item 23a) (Type, Print), South Greene Street, Baltimore, MD Matthew Smit 22 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

2005

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Collins Shirley AMM April 2005 0300 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death University of Maryland Medical Center Baltimore N/A 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) **Funeral**  Birthplace (State or Foreign Country) 1□M 2□F Director 72 214-30-4167 10, 1933 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. and tems 27 is marked other than "neturel", or Items 23e or 28e-f show 10a. State 10b. County 10c. City, Town or Location "neturel", or Items 23e or 28e-f show olical Examiner is ust be nutified at 10d. Inside City Limits Director 1 Yes 21 No Shelbyville Delaware Sussex 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 19975 22G Blue Bill Drive Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc 1 ☐ Never Married 2 X Married 1 ∐ Yes 2%∑ No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 white 1 ☐ Yes 2 ☐ No Specify: 3 Widowed 4 Divorced other traumatic event, It's Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) own home homemaker 12 years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Cecelia Dell Norris Timmons ဂ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 22G Blue Bill Drive, Shelbyville, Delaware 19975 Burnett Collins/husband 20a. Method of Disposition
1 🗆 Burial 2 🗆 Cremation 3 🗆 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State ò permit. Page Department of Importent: If any injury or once. 4/26/2005 Baltimore, Md. Bayview Crematory ` 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Home of Bel Air, Inc. Buen a. 610 W. MacPhail Road, Bel Air, Md. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval 8etween Onset and Death Immediate Cause (Final Physician esophageal cancer disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of): for use as the burial-transit Hospitel or Attending Physicien: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Box 68760. attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 4☐ Pregnant at time of death Month Day Year 5 Other (specify) P.O. the 9☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Be Completed by Mellitus Diabetes 3 Probably 4 Unknown Yes 2 No pertension 24a, Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No certificate has performed 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No Certification; To 1 X Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No nours after death.

nerel Director: A
filled in by the for investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funerel D Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2 Heidi Karon NID P17708 April 22, 2005 0 1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 22 South Greene Street, Batimore, Maryland 21201 Heiae Karon MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2005 Registrar

Registrar DHMH 17 Rev 1/2001

State

Peter

31. Date filed (Month, Day, Year)

APR 26

Universit

2011

32. Registrar's Signature

P.O. Box 68760 Division of Vital Records.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year **Physician** Marlan Α. Church 2005 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death County of Death Examiner Center Hospital Kosedale

If Under 1 Year | If Under 24 Hrs. TIMOLE mare 8. Date of Birth (Month, Day, Year) March 4, 1934 7 Age (In yrs. last birthday) 71 Yrs. Social Security Number 9. Birthplace (State or Foreign **Funeral** Days 1 M 2 □ F 427-58-7909 Virginia Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show other traumatic event, the Medical Examiner noist be notified at 1 ☐ Yes 2 ☑ No Funeral Director White Marsh Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5606 Ranelagh Road 21162 U.S.A. or Items 23a 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No Specity: White Be Completed by 3 X Widowed 4 □ Divorced 'natural' 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Steel Company Carpenter 6th Grade permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked other any injury or other traumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) William Church Pickelsimer Viola 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 518 Crisfield Road, Baltimore, MD 21220 Mr. Garry Church (son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Holly Hill Mem'l Park 4/27/2005 Baltimore, Maryland ' 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Schimunek Funeral Homes 21. Signature of Funeral Service Licensee 9705 Belair Rd., Baltimore, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): by Physician/Medical Examiner Due to (or as a consequence of): inding physician a use as the burial-IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☑ Yes 2 □ No 3 □ Probably 4 □Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 200 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 No pital: 1 Inpatient 2 28a. Date of Injury (Month, Day Year) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 28c. injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) à 4 Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number Res 0000 MS 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Franklin Square Prive Baltimore MD 21237 31. Date filed (Month, Day, Year) APR 2 6 2005 Registrar

			Please Type or Prin				•	•	
		State of Maryland / Department of Health and Mental Hygiene							11.035
			1 - State Registrar		Certificate of		Reg.	No. 0 0 0	19000
	Physici /Medic	an	1. Decedent's Name (First, Middle, Last)	try (	Callaha	n Ap	ril 2	Day Year 2 001	
	Examin		4a. Facility Name (If not institution, give street and number)	Cen-	4b. City, Town, o	Location of Death		4c. County of Death n/a	1
	Funeral		5. Social Security Number 6. Sex 7. Age	(In yrs. last bil	rthday) If Under 1 Year	If Under 24 Hrs. 8, Date	e of Birth nth, Day, Yea	9. Birth	place (State or Foreign
	Director		218-30-5374 1 M 2 X F Usual Residence of Decedent	91	Yrs. Months Days				aryland
	show	7	10a. State 10b. County  Maryland Talbot	10c. City, Tow	n or Location ordova				10d. Inside City Limits 1 ☐ Yes 2 No
	ith the M or 28a-f	Funeral Director	10e. Street and Number 11778 Old Skipton Road		10f. Zip Code	 525		Citizen of What Cou	untry?
	eath w	eral	11. Marital Status 12. Was Decedent	ever in U.S.				ited Stat	
21215-0036	nit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland ariment of Health and Mental Hygiene. ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examinat must be notified at a layer.	by Fun	Armed Forces?  1 Never Married 2 Married  3 X Widowed 4 Divorced  Armed Forces?  1 Yes, Give Year or Dates:		If Yes, specify Cuba 1 ☐ Yes 2X No	lispanic Origin? (Specify Ye an, Mexican, Puerto Rican, o Specify:	etc.)	Black, White	
	72 ho natur	eted	15. Decedent's Education (Specify only highest grade completed)	16a	Decedent's Usual Occup	during most of working	16b.	Kind of Business/I	ndustry
121	within iene. than	Completed by	Elementary/Secondary (0-12) College (1-4or 5	+)	Registe:	red Nurse		Hospi	tal
Maryland	should be filed nd Mental Hyg marked other matic event, l	To Be C	17. Father's Name (First, Middle, Last) Thomas E. Davis			18. Mother's Name (First, Mary	Middle, Maid E. Fre		
	and 2 shou Balth and M n 27 Is mai		19a. Informant's Name/Relationship (Type, Print) Donald Callahan / Cousin			and Number or Rural Route		•	
	of Hea of Hea of Hea of Hea of He		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State	20b. Place o	of Disposition (Name of ary, crematory or other place	Date Date	20c.	Location - City or 1	Town, State
Baltimore,	Pages Iment of I tant: If its jury or o		□ Donation 5 □ Other (Specify)	Loude	on Park Ceme	tery 4/26/05		ltimore,	_
Ball	permit. Pages 1 and. Department of Health Important: If item 27 any injury or other tr		2) Signature of Funeral Service Licenses	<u> </u>		ss of Facility Hubbar ens Avenue, F			
	Physician		23a. Part1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each list immediate Cause (Final disease or condition		not enter the mode of dyir	ng, such as cardiac or respir	atory arrest,		Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)  Due to (or as	a consequence	of): Vexia				months
		Jer	Sequentially list conditions. If any, leading to immediate cause. Enter Underlying	a consequence					101011111
	te be executed ysician and te buriat-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):						
760,	be exe ician a burial-	cai Ex	Due to (or as	a consequence	01):				
687	ficate physi s the l	adica	d						
.O. Box 6	that the death certificate ed by the attending phys detached for use as the	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 mm of this? 1 □ Yes 2 ☑ No 9 □ Unknown	2 Fetal death	n 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) _	1		23d. Date of deli	very Day Year
<u>α</u>	that the ned by detac	by Phy	Part II. Other significant/conditions contributing to death b	ut not resulting i	in the underlying cause giv	en in Part I. 23	e. Did tobacc	o use contribute to	the cause of death?
rds	iw requires that s been signed t s should be det		Hypertension				1 ☐ Yes	2 □ No 3 □ Pro	obably 4 Onknown
Reco	has has	Completed	_ Unemia				a. Was an autopsy performed	death?	topsy findings available completion of cause of
/ita	Physician: The this certificate rail director, pag	Be	25. Was case referred to medical examiner?		Oth	26. Place of Death (Chec			
of	% ≤ <del> </del>	- To	1 ☐ Yes 2 ☐ No ☐ Hospital: 1 ☐ Inpatie  27. Manner of Death 28a. Date of Inju			4 Mursing Home 5			ufy)
Division of Vital Records,	Attending r death.	ation	27. Manner of Death 28a. Date of Injury 28b. Time of North? 28b. Time of North? 28c. Injury at Work? 28d. Describe how injury occurred Work? 1 Accident investigation  North N						
	i i i i	Certification;	3 Suicide 6 Could not be determined 28e. Place of Inj building, et	ury - At home, la c. (Specify)	arm, street, factory, office	28f. Loc Cit	cation (Street y or Town, St	and Number or Ru ate)	ral Route Number,
	Nospital or 124 hours after the Funeral Direction in the Funeral Direction in the filled in the fill	edical (	29a. Certifier  (Check only one)  1 Certifying Physician: To the best 2 Medical Examiner: On the basis or and manner sta	examination at	e, death occurred at the tind nd/or investigation, in my o	ne, date and place, and due pinion, death occurred at th	to the cause e time, date a	e(s) and manner as and place, and due	stated. to the cause(s)
	To the within 2. To the Complet	Me	29b. Signature and title of certifier	ino	29c. Licens	e number	29d.	Date signed (Month	n, Day, Year)
/	151		30. Name and address of person who completed cause of d	eath (Item 23a)	(Type, Print)	3 3 7 1	11	1. 122,	2003
	V	10	Ming Vi 3320 Benson  31. Date filed (Mohth, Day, Year)  32. Begistr	ar's Signature	enne. B.	altimore	Mary	1 (and	21227
	Sta Regist		APR 2 6 2005	J.K	frede				

DHMH 17 Rev 1/2001

ORIGINAL

UCE	CHASSE	REA	State of Maryland / Department of Health and I 1- For State Unpend Item 23a,27,28a-f per me 6842,4-28-05, tas Certificate of Death	ب Mental Hyو F	giene 005	14036
	Physici	an	1. Decedent's Name (First, Middle, Last)	2. Date of Dea Month		3. Time of Death
	/Media	al	Bruce C. Chassereau	APRIL	13, 2005	1907 Р м
0	Examir	ıer	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 1912 MAUDLIN AVENUE  BALTIMORE CITY	1	4c. County of Death	
Ö	Funeral		5. Social Security Number  6. Sex  7. Age (In yrs. last birthday)   If Under 1 Year   If Under 24 Hrs.    1	(Month, Day	(, Year) Cou	place (State or Foreign
Z	Director		218-92-3651 1 Me 2 F 32 Yrs. Months Days Hours Min. Usual Residence of Decedent	Sept.	24, 1972 Mai	cyland
	aryland show		10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
	the Ma 28a-f s	Director	Maryland N/A Baltimore			1X Yes 2 No
	with the		106. Street and Number  1912 Maudlin Avenue  21230		10g. Citizen of What Cou USA	ntry?
	be filed within 72 hours after death with the Maryland Ital Hygiene. d other than "neturel", or Items 23e or 28e-f show event, the Medical Examera must be rotified at	Funerai	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent of Hispanic Origin? (S) If Yes, specify Cuban, Mexican, Puert	pecify Yes or No-		
36	or Ite		1 □ Never Married 250 Married 1 □ Yes 250 No If Yes, Give 1 □ Yes 250 No Specify:	o Alcan, etc.)		eic. Vhite
00	hours turel'	ed by	3 Wildowed 4 Divorced Year or Dates:  15. Decedent's Education   16a. Decedent's Usual Occupation		16b. Kind of Business/Ir	
215	hin 72 9. an net	Completed	(Specify only highest grade completed)  (Give kind of work done during most of work life. DO NOT use retired)  (Give kind of work done during most of work life. DO NOT use retired)	king	Too. Ning of Bushingsyn	idustry
21	illed with Hygiene. other thai	Con	12 Arborist		Self Emp	loyed
Maryland 21215-0036		To Be	17. Father's Name (First, Middle, Last)  Bruce W. Chassereau Deanna	• • •	Maiden Sumame) La	ımbert
	s 1 and 2 should f Health and Men item 27 Is marke other traumatic		19a. Informant's Name/Relationship (Type, Print)  Lisa Chassereau (Wife)  19b. Mailing Address (Street and Number or Ru 1912 Maudlin Ave., Bal			Code)
Baltimore,	es 1 and 2 of Health of fitem 27 is r other tra		20a. Method of Disposition  1 XBurial 2 Cremation 3 Removal from State	Date	20c. Location - City or To	own, State
ţi	Pages tment of I tent: If it		`4 □Donation 5 □Other (Specify) Loudon Park Cemetery   4/18	3/05	Baltimore,	Maryland
Bal	permit. Pages: Department of H Importent: If ite any injury or of		21. Signature of Funeral Service Licenses  22. Name and Address of Facility  3620 Wilkens Ave.,		ck Funeral H	
	**		23a Perf. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line.			Approximate Interval Between
	Physician /Medical	35 1	Immediate Cause (Final disease or condition resulting in death)  a. Heroin Intoxication		6	Onset and Death
	Examiner		Due to (or as a consequence of):			
	P =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause the teach of the tea		-	
	be executed ician and burial-transit	Examiner	Cause (Ulesaes or injury that initiated events resulting in death) Last  Due to (or as a consequence of):			
8760,	cate be ex physician the buria	dical E	Suc to (or us a consequence of).			
9	tificate ng physi as the	ledic	0.		-	
Вох	eath certific attending p	an/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy  1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy		23d. Date of deliver	ery Day Year
P.O. I	that the dea ed by the a detached f	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 4 ☐ Pregnant at time of death 5 ☐ Other (specify)		, month	<b>54</b> , 154,
	Attanding Physicien: The law requires that the death certific releath. sctor: After this certificate has been signed by the attending p by the funeral director, page 2 should be detached for use as	by Physician/Me	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did to	bacco use contribute to t	he cause of death?
Vital Records,	w require been sig should b	ted k		1 🗆 Y	es 2 No 3 Prot	pably 4 Unknown
leco	e lawr has be e 2 sh	Completed		24a. Was a autops perform	sy prior to co	psy findings available impletion of cause of
alF	ician: The l certificate ha ector, page		OF Was are referred to realize	1 Yes	2□No 1A Yes	2□ No
Vit.	ysicien: is certific director,	To Be		th <i>(Check only on</i> ome 5 □ Beside	ence 6 Xother (Specif	y) AT SCENE
Division of	ding Phys h. After this funeral di	J. L	27. Manner of Death 28a Date of Injury 28b Time of 28c Injury at		ow injury occurred	unk
siol	ttendir death. stor: Al	catic	2 Accident investigation 4-13-05 7:00 PM 1 Yes 2 No			
Divi	= e = -	Certification;	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  Found at residence	City or Town	treet and Number or Rura n, State) <b>1912 May</b> re, Maryland	dlin Ave.
	To the Hospitel or Attending Ph within 24 hours after death.  Jo the Funerel Director: After th completely filled in by the funeral	edical C	29a. Certifier (Check only one)  1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place. 2X Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occur and manner stated.	and due to the c	ause(s) and manner as s	tated.
	To the within To the Comple	Me	29b. Signature and title of certifier 29c. License number	2	9d. Date signed (Month,	
	D. E.		→ hy hu, m.D OCME		APRIL 14,	2005
į	alh		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  111 Penn Stre	et Balt	imore, Mary	land 21205
	Sta	ite	31. Date filed (Month, Day, Year) 32. Registrar's Signature	Dart	TICLL 9	10110 2120)
	Regist	ar	ADD 9 6 2005 Ready At April			

State of Maryland / Department of Health and Mental Hygiene [] For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 917PM K:m Apr: 2003 CHAU /Medical 4c. County of Deeth 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) **Examiner** 5925 Baltimore Street Baltimore Catonsville If Under 1 Year | If Under 24 Hrs. 8 Date of Birth (Months Days Hours Min. (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Social Security Number **Funeral** Days 473-96-6764 1 ☐ M 2 💢 F 35 Director March 10. 1970 Viet Nam Usual Residence of Decedent death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits th and Mental Hygiene. ?? is marked other than "natural", or items 23a or 28a-f show traumatic event, the Modical Exercit er must be notified at 1 ☐ Yes 2 No Baltimore Catonsville Maryland Direct 10g. Citizen of What Country? 10e. Street and Number 10f, Zip Code 21207 United States 5925 Baltimore Street Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Bleck, White, etc. Pages 1 and 2 should be filed within 72 hours after Never Married 2 ☐ Married 1 ☐ Yes 2X No If Yes, Give 1 Yes 2 No Baltimore, Maryland 21215-0036 Specify Specify Vietnamese þ 3 Widowed 4 Divorced Year or Dates ted 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Complet Elementary/Secondary (0-12) Gollege (1:4or 5+) never employeed -- N/A --18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Lien Nguyen Duyen Chau 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2.
Department of Health a Important: If item 27 is any injury or other trau 5925 Baltimore Street Catonsville, MD 21207 Father Duyen Chau 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □Donation 5 □Other (Specify) Baltimore Washington Crematory April 22, 2005 Laurel, Maryland 22. Name and Address of Facility Loring Byers Funeral Directors, Inc 21. Signature of Funeral Service Licensee y . Kollner M00333 8728 Liberty Rd. Randallstown, MD 21133-4784 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final AS PHYXIA BY HANGING - Suicide **Physician** 10 minutes disease or condition resulting in death) /Medical Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 24a. Was an has autopsy perform certificate 1 Yes or Attanding Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1XYes 2□No 3□ DOA 1 Inpatient 2 ER/Outpatient Certification: To 28b. Time of Injury 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 1 Natural 5 Pending e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 1 🗌 Yes BY HANGING investigation 2 Accident Director: 6 Could not be determined 3 Suicide 4 ☐ Homicide 28f. Location (Street a filled in by HOME within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) हिंच address of person who completed cause of death (Item 23a) (Type, Print) eH:11 CT. Lythenville, MD 6 Trimbl 31. Date filed (Month, Day, Year) Registrar's Signature State APR 26 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

				State of Ma	-	epartmer <i>Certifica</i>				giene Reg. No.2 0	05	14038
	Physici		1. Decedent's Name (First, Middle, Lest Angelia	) Virginia (	Cox				2. Date of Dec Month April	oth 20, 200!	Year 5	3. Time of Death 4:30 P
0	/Medic Examin Funeral Director		4a. Facility Name (If not institution, give Waldorf Health C  5. Social Security Number 6. Se 579 12 6220	are Center	(In yrs. last birt	hday) If Unde Months	er 1 Year	Waldorf If Under 24 Hrs. Hours Min.	8. Date of Birt	Cl	narles	S. lace (State or Foreign hy) nington DC
	_	Director	Usual Residence of Decedent  10a. State 10b. County  Maryland Charles  10e. Street end Number		10c. City, Towr	ite Pla	ins			10g. Citizen of	10	0d. Inside City Limits 1 ☐ Yes ♣☐ No
	3a or		4225 Southwinds	Place		101. 21		20695		United		·
020	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "netural", or itams 23a or 28e-1 show any injury or other traumatic avent, if a Medical Evantion I must be inclined at once.	by Funeral	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3\text{XWidowed} 4 ☐ Divorced	12. Was Decedent Ex Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:			ž.	lispanic Origin? (Spo an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Rad Bla	ce-America ck, White, e y: Whit	etc.
Maryland 21215-0020	within 72 hou iene. • than "neture"	Completed	15. Decedent's Edu (Specify only highest grad	cation e <i>completed)</i> College (1-4or 5+	1 _	Decedent's Usu (Give kind of w life. DO NOT t Pautici		etion during most of work i)	ing	16b. Kind of B		lustry
and	d be filed ental Hyg ed other c avent,	Be	17. Father's Name (First, Middle, Lest)  James Leo DeC	hard				18. Mother's Name		Maiden Suman Phillii		
Mary	d 2 shoul th and Me 7 Is mark traumati	ဥ	19a. Informant's Name/Relationship (7) Angela M. Huff (	rpe, Print)	19b. 4	Mailing Addres	s (Street	and Number or Rure	el Route Numbe	r, City or Town,	State, Zip	<sub>Собе)</sub> 20695 ins, MD
Baltimore,	ages 1 an nt of Heal t: If item 2 f or other		20a. Method of Disposition  1XXBurial 2 Cremation 3 F	lemoval from State				April 25	, <sup>D</sup> 2005	20c. Location	_	
Baltir	permit. P Departme Important any Injury once.		4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service Licens	1 1	3t. re	22. Name a	nd Addre	Cemeterly ss of FacilityLee a Ferry Ro		L Home,	Inc 66	
4	tificate be executed  g physician and as the bunlel-transit	edical Examiner	23a. Part1. Enter the disease, or complishock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause, Disease or injury	PARA	WHi C ue to (or es e c	onsequence of)	=U.	S	or respiretory er	rest,		Approximate Interval Between Onset and Death  Mery TH S
3ox 68760,			that initiated events resulting in death) Last		ue to (or as a c	onsequence of):	•					
P.O.	v requires that the death cer been signed by the attendin should be detached for use	Physician/N	Part II. Other eignificent conditions cor	tributing to death but	not resulting in	the underlying	cause giv	en in Part I.			ntribute to 3 ☐ Prob	the cause of deeth?
Records, P.O. Box	2 5 2	Completed by							24a. Was o	en autopsy med?	avai	re eutopsy findings ilable prior to npletion of cause leath?
ă B	: The i								1□ Y	es 2 No	10	Yes 2□ No
Ž	sician: The	To Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☐ No	lospital:	2 ☐ ER/Out	patient 3□ D	OA Oth	er: Nursing Ho			er (Snecify	)
Division of Vital	To the Hospital or Attending Physician: The is within E Vaheurs effect death.  To the Funeral Director: After this certificate he completely filled in by the funeral director, page	atlon: T	27. Manner of Death  1 Natural  2 Accident  5 Pending investigation	28a. Date of Injury (Month, Day	28b. T		28c. Injur Wor			ow injury occur		
DIVIS	To the Hospital or Attending I within 24 hours effer death. To the Funerel Director: After completely filled in by the fune	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injur building, etc.	y - At home, far (Specify)	m, street, factor	ry, office		28f. Location (S City or Tow	itreet and Numb n, State)	er or Rural	Route Number,
	To the Hospital or within 24 hours efte To the Funerel Dir completely filled in	edical	29a. Certifier (Check only one)	sicien: To the best of ner: On the basis of e and manner state	xamination and							
	To the Within Comp.	M	29b. Signature and title of certifier	Ait	ENDIA	J 29	D.	e number 44430		29d. Date signed	d (Month, D	lay, Year)
,	2,		30. Name and address of person who co	mpleted cause of dea	th (Item 23a) (	Type, Print)	11	e number 44436	f Ashv	in J.2P	atel.	M.D.
	Sta Registr	15	31. Date filed (Month, Day, Year) APR 2	6 2005 gistran	Signeture	15 A	MARK		/ / 111		- 00	

		1 - For State Registrar	State of M	aryland / Dep	ertificate of			giene () (	)5	140	39
Phy	sician	Decedent's Name (First, Middle,     Marris Marris Co.					2. Date of Dea Month	th Day	Year	3. Time of 0	Death AM
	edical miner	Anne Marie Co			4b. City, Town, o	or Location of Death	April	23, 20 4c. County	005 of Death	0.20	
		Suburban Ho			Beth			_	gomer		
Fune Direc		5. Social Security Number 018–34–2894	5. Sex 7. Ag 1 ☐ M 2 🖾 F	ge (In yrs. last birthday 61 Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day Jan. 6	7 7, Year) 1944	9. Birthp Coun	lace (State or itry) achusei	Foreign ++c
- P		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or L	ocation			, 1544		0d. Inside City	
Maryla	to	Maryland Montgo	nme rv	Bethes						1 🗌 Yes	
ith the	Director	10e. Street and Number 9718 Corkran 1		Deches	10f. Zip Code			10g. Citizen of	What Coun	itry?	
5-0036 72 hours after death with the Maryland netural', or items 23s or 28s-1 show that Farmer 18 the restrict of the state of the stat	erai	11. Marital Status	12. Was Decedent	Sverio II S 13	20817	dispanie Origin? (Sr	andry Vac or No.	Unite	d Sta		
6 atter d	Funeral	1 Never Married 2 Marrie	Armed Forces?  id 1 ☐ Yes 2 ☑		. Was Decedent of H		Rican, etc.)		ck, White,	etc.	
Maryland 21215-0036 at 2 should be filed within 72 hours att lith and Mental Hygiene. 27 Is marked othar than "natural", or traumatic awant at the Moutest Franch	d by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	l too Doo	1 ☐ Yes 2 🐼 No			Specif			
215 30 "ng 20 "	Completed	15. Decedent's (Specify onfy highest Elementary/Secondary (0-12)	grade completed)  College (1-4or	(Giv	edent's Usual Occup e kind of work done DO NOT use retire	during most of world)	king	16b. Kind of B	usiness/inc	ustry	
212 led wit lygiene har the	Con		2		Buyer		( <del>-</del>	Reta			
land id be fi ental H ked off	To Be	17. Father's Name (First, Middle, L William J. Coro				18. Mother's Nam			ne)		
ary lary and M	۲	19a. Informant's Name/Relationshi	p (Type, Print)	1.7	ling Address (Street	and Number or Rui	rai Route Numbe	r, City or Town			
e, M eaith		William M. Co	orcoran/Brot		John Ros		rownsvi Date	lle, Ma			2
DS Ammimore, Mimore, M		1 ☑Burial 2 ☐ Cremation  1 ☑Donation 5 ☐ Other (Sp.		Gate of Gate	position (Name of ematory or other place in the aven	April	L 27,	Silver	,		v1 and
23 05  Baltimore, Maryland 21215-0036  permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Improvant: If item 27 is marked other them? "netural; or items 23a or 28e-1 ehow any holicy or other transmits event item." Medical Equipment of the training to sent item.	once.	21. Signatule of Funeral Service L		В	etery <sup>22. Name and Addre</sup> ethesda-C ethesda, ]	ss of Facility Roh	ert A. l se, Inc.	umphre 7557 W	y Fun Lscon	eral Hosin Ave	ome/ enue
Physici	an	23a. Part1. Enter the disease, or of shock, or heart failure. List of Immediate Cause (Final disease or condition	nly one cause on each li	d the death. Do not er	nter the mode of dyir	ng, such as cardiac				Approximate Interval Betwo Onset and De	een
/Medio	al	resulting in death)	-	a consequence of):	31100						
		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as	a consequence of):	RACE 11	o FECTIO	29				
A NN 60, 60, 60 executed ian and ian and initial-transit	Examiner	that initiated events	3015	MODIA							
8760, sate be executed hysician and the burial-transit		resulting in death) Last	Due to (or as	a consequence of):							
687 dificate g phys	edica		d	W LINIT	- کوچری ،		· · · · · · · · · · · · · · · · · · ·				
C XO	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal death 3	□Ectopic pregnancy □ Other (specify) _	у			te of delive onth	ry Day Ye	∍ar
	by	Part II. Other significant condition	s contributing to death b	out not resulting in the	underlying cause giv	ven in Part I.		bacco use con es 2 Do		e cause of de ably 4 ∐Ur	
0 0 00	0						24a. Was a autops perfor 1 Yes	sy med2	Were autor prior to con death? 1 \(\sum \) Yes	osy findings av	/ailable use of
Vita sicien: certific	Be (	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☐ No	Hospital:	• E = 0 = 0	ont 3C DOA Oth	26. Place of Deal				E3 635	
Division of Vital Re To the Hospital or Attending Physicien: The I within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director. page	ation; To	27. Manner of Death  1 Aatural 5 Pending 2 Accident investiga			of 28c. Injur	4 🗀 Nursing no	ome 5 Resid			")	
Division Attention State des al Director and in by the	Certification:	3 ☐ Suicide 6 ☐ Could no determin	28e. Place of In	jury - At home, farm, s c. (Specify)	treet, factory, office		28f. Location (S City or Tow	treet and Numb n, State)	oer or Rurai	l Route Numb	97,
ha Hospi iin 24 hour the Funer	edicai	one) 2 Medical E	Physician: To the best xaminer: On the basis and manner s	if examination and/or i	nvestigation, in my o	pinion, death occur	and due to the c red at the time, d	ause(s) and mail late and place,	anner as sta and due to	ated. the cause(s)	
To 1	Σ	29b. Signature and title of certifier	Jana !	X	29c. Licens	se number		29d. Date signe	•		
		30. Name and address of person w	no completed cause of c	death (Item 23a) (Type		シベックバアの	ديد	4-2	3-7	E05	
10		ANDERSHIPANA	A-DEAGE G	2 6.0	5622 Shie	lds Drive	Bethe	sda, Ma	rylan	d_2081	7
Reg	State istrar	31. Date filed (Month, Day, Year)  APR	2 6 2005	Lagran J	positi						

		1 - For State Registrar	laryland / Depa <i>Cei</i>	rtificate of l			Reg. No.	CU	14040
Physic	ian	1. Decedent's Name (First, Middle, Last)				2. Date of De	ath Day	Year	3. Time of Death
/Medi Exami	cal	Barbara Ann Crisaw  4a. Facility Name (If not institution, give street and number		4b. City, Town, or	Location of Death	April	4c. Coun	ty of Death	12706 AM
EXAIIII	iiei	University of Maryland Medi	6 6	Balti				Himore	
Funeral Director		223-46-4472 1□M 2K⊠F	ge (In yrs. last birthday) 67 Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Bird (Month, Da April 15	, 1938	9. Birthpl Count 01ney	ace (State or Foreign try) Maryland
land bw		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or Lo	ocation				10	Od. Inside City Limits
Mary B-f sh	tor	Maryland Montgomery	Damascus						1 ☐ Yes 21X No
or 28	Direc	10e. Street and Number		10f. Zip Code			10g. Citizen o		•
eath w	Funeral Director	26212 Kings Valley Road  11. Marital Status  12. Was Deceden	t Ever in U.S. 13.1	20872		ecify Yes or No	United	State ace - America	
I and 2 should be filed within 72 hours after death with the Maryland I health and Mental Hygiene. I health and Mental Hygiene. I health are 13a or 28a-f show itam 27 is marked other than "natural", or itams 23a or 28a-f show other treumstic avent, the Medical Examinar must be notified at	by Fun	Armed Forces  1 □ Never Married 2 ☑ Married  1 □ Yes 2 ☑  3 □ Widowed 4 □ Divorced  Armed Forces  1 □ Yes 2 ☑  If Yes, Give Year or Dates	No	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 217 No	in, Mexican, Puerto Specify:	Rican, etc.)		ack, White, e	etc.
72 hou	eted	15. Decedent's Education (Specify only highest grade completed)	16a. Dece	dent's Usual Occup kind of work done o DO NOT use retired	ation during most of work	ina	16b. Kind of	Business/Ind	lustry
12 should be filed within h and Mental Hygiene. 7 Is marked other than "reaumatic avent, the Men	Completed	Elementary/Secondary (0-12) College (1-4or	(5+) life.	DO NOT use retired Homemak		3	Own	Ноте	
filed Hygie other	Be Co	17. Father's Name (First, Middle, Last)	<u> </u>	Homemak	18. Mother's Nam	e (First, Middle,			
wild be fill Mental Hy arkad oth	To B	Joseph Walker			Laura Wr	ight			
12 sho n and l		19a. Informant's Name/Relationship (Type, Print) Richard E. Crisamore, Jr./H		ng Address (Street				-	-
es 1 and 2 of Health litem 27		20a. Method of Disposition	20b. Place of Dispo			Date	20c. Location		
Pages nent of nt: If i		1   Burial 2 □ Cremation 3 □ Removal from State  4 □ Donation 5 □ Other (Specify)	Monocacy		<sup>(a)</sup>   Apri   200	1 22, )5	Bealls	ville,	Maryland
permit. Pages Department of H Important: If its any injury or of	100	21. Signature of Funeral Service Licen lee	105689 Re	2. Name and Address ockville, Rockvil	ss of Facility Rob Inc. 30 le, Maryl	ert A. 00 West	Pumphr	ey Fun	eral Home/ venue,
		23a. Flart Lengryle disease, or complications that caus shock for heart failure. List only one cause on each	ed the death. Do not ent line.						Approximate Interval Between
Physician	_	resulting in death)	heumonia						Onset and Death
/Medical Examiner	_	Due to (or a	lymphocytic	leukem	· a				
	je l		s a consequence of):	(Collection	100				
ecuted and -transi	Examiner	that initiated events c.	is a consequence of):						
ificate be executed g physician and as the burial-transit	edical E	d	a consequence or).						
		IF FEMALE: 23c. If yes, outcom	ne of pregnancy				234 [	Date of delive	0/
The faw requires that the death certifule has been signed by the attending bage 2 should be detached for use as	hysician/M	in the past 12 months?	2 Fetal death 3 at time of death 5	⊒Ectopic pregnancy ⊒ Other <i>(specify)</i>	'				Day Year
s that t ned by e detai	by Ph	Part II. Other significant conditions contributing to death	but not resulting in the u	inderlying cause giv	en in Part I.	23e. Did t	obacco use co	entribute to th	e cause of death?
w require been sig should b						1 🗆	Yes 2 □ No	3 Prob	ably 4 Deinknown
The law requires t ate has been signe page 2 should be o	ompleted					24a. Was auto perfo 1 \( \text{Yes} \)	psy prmed?	o. Were autop prior to con death? 1 ☐ Yes	osy findings available inpletion of cause of 2 No
ysiclan: The is certificate director, pag	BeC	25. Was case referred to medical examiner?		211	26. Place of Deat				
Physi r this c	P.	1 ☐ Yes 2 ☒ No Hospital: 1 ☒ Inpa  27. Manner of Death 28a. Date of Ir			4   Nursing H	ome 5 Resi			′)
- 6 a a	ation	1 Natural 5 Pending (Month, D	Day Year) Injury	Wor		200. 2000.100	not injury ood	31100	
I or Attending after death. I Director: Afte	Certification;	3 Suicide 6 Could not be determined 28e. Place of	njury - At home, farm, st etc. <i>(Specify)</i>	reet, factory, office		28f. Location ( City or To		nber or Rura	I Route Number,
Hospita 4 hours Funaral	Medical C	29a. Certifier (Check only one)  1 Cartifying Physicien: To the besis and manner	of examination and/or in	th occurred at the timestigation, in my o	me, date and place, pinion, death occur	and due to the red at the time,	cause(s) and date and place	manner as st e, and due to	ated. the cause(s)
To the within 2 To the complet	Me	29b. Signature and title of certifier		29c. Licens	e number		29d. Date sign		Day, Year)
0		I Afre Groke M.D.			14433		4/20/	05	
10		30. Name and address of person who completed cause of Steven Epstein 22 S.	f death (Item 23a) (Type,	Print) Streat	s Bultimor	e, Mary	and 2	1201	
S Regis	tate trar	30. Name and address of person who completed cause of Steven Epstein 32. Registration of Steven Epstein St	strar's signature	B. Apart					

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death **Physician** /Medical 4b. City, Town, or Location of Death Examiner last birthday) 7. Age (In yrs **Funeral**  Birthplace (State or Foreign Country) 1**X**M 2□ F Months Days Director Usual Residence of Decedent with the Maryland 10a State 10b. County 10c. City, Town or Location ehow 10d. Inside City Limits :7 is marked other than "natural", or Items 23a or 28a-f ehov traumatic event, the Medical Examinar must be notified at Director 1 Pres 2 □ No more 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funerai Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or Ite 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 þ 1 ☐ Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced Specify: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, mant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Fural Route Number, City or Department of Health a Important: If Item 27 is any injury or other tra d of Disposition 20b. Place Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Eur 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) ML Z /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ģ in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 5 Other (specify) 4 Pregnant at time of death the detached 9□ Unknown 9 ☐ Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ page 2 should Be Completed 2 No 1 ☐ Yes 3 Probably 4 Unknown 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? certificate has 2 No 1 ☐ Yes 2 🗆 No 1 Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one, examiner' Hospital: 1 Tes Other: Certification: To 2 ER/Outpatient this 1 Inpatient 3□ DOA Wursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) After t 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Natural Injury 5 Pending after death. 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 🗌 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) To the within 2 29b. Signature and title of certifier 29d. Date signed (Morth, Day, Year) DOV25662 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3333 CALVERTST GREGORY egistrar's Signatur Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 22 22 **Physician** 2005 April 7:15 A M Sr. Docos Tony /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Anne Arundel Mariner Health at North Arundel Glen Burnie If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year)
Dec 16, 1930 Birthplace (State or Foreign NY
 NY 7. Age (In yrs. last birthday) 5 Social Security Number 6. Sex **Funeral** 1**∑**M 2□F 74 Director 073-24-7604 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. inside City Limits 10a State 10h Counts 28a-f show other traumatic event, the Medical Examinar ruest be notified at 1 ☐ Yes 2 ☑ No Director Anne Arundel Glen Burnie 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 5 7885 Gordon Court # 584 21060 U.S.A. Items 23a death Funera permit. Pages 1 and 2 should be filed within 72 hours aftar deal Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural". ~ "--- any injury or other traumatic average. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐XNo Specify: white Specify: þ 3 ☐ Widowed 4 ☐ Divorced Year or Dates Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Coilege (1-4or 5+) General Motors 12 Foreman 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Anna Abbotangelo George Docos 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3438 2nd Street, Brooklyn, MD 21225 Mrs. Diane Martin/ daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State Glen Haven Mem. Park Apr. 25, 2005 Glen Burnie, MD \* 4 □ Donation 5 □ Other (Specify) 21. Signature of Frieral Service Licenses 22. Name and Address of Facility Singleton Funeral Home P.A. [101319 1 Second Avenue S.W., Glen Burnie, MD 21061 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Luce /Medical consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter the cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner be executed burial-transit Due to (or as a consequence of) Box 68760, attending physician Physician/Medicai use as the IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of deliver 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No for 4☐Pregnant at time of death 5 Other (specify) the ( Division of Vital Records, P.O. detached 9 Unknown 9 Unknown signed by Ather significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Part II þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Spinknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No 1 ☐ Yes 2 No Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifice Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Cther: 4 Nursing Home 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify, ပ 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural М 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title 0 0 person who completed cause of death (Item 23a) (Type, Print) 30. Name and address of i Whi 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

			For State	tate of Maryland		artment of H tificate of I		ntal Hygi	ene 2005	14043
			Registrer  1. Decedent's Name (First, Middle, Last)		Cei	uncate or i		Reg	g. No.	3. Time of Death
	Physicia		0	ELIO A L	DE LAV	PAZ-		Month Angil	Day Yeer 2.4 2003	5:20 A.M.
	/Medic Examin		4a. Facility Name (If not institution, give stree	et and number)			r Location of Death	The c	4c. County of Dea	
			JOSEPH KITCHEY H			BALTIN	MORE			
	Funeral Director		5. Social Security Number 6/Sex 12/M	7. Age (In yrs. Ia	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. 8 Hours Min.	Date of Birth (Month, Day, 1997) MARCH 30		thplace (State or Foreign
			Usual Residence of Decedent	6.7				714KCH 3C	3 (128 ) [AL	CIPPINES
vla	show	_	10a. State 10b. County		, Town or Lo	_				10d. Inside City Limits 1 ☐ Yes 2 ☑ No
M ed	88 	ecto	MARYLAND HARTORD	6	UNP	10f. Zip Code		10	g. Citizen of What C	
death with the Marvland	a or	Funeral Director	10e. Street and Number	ie	,		1010	10	PHILIPPINE	
death	ms 23	nera	11 Marital Status 12.1	Was Decedent Ever in U.S	S. 13.		lispanic Origin? (Speci an, Mexican, Puerto Ri	fy Yes or No-	14. Race - Ame	erican Indian,
-	or Ita	/Fur	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give	- 1	1 ⊈Yes 2 12 No	an, mexican, Puerro Hi  Specify:	can, etc.)	Black, Whi	
21215-0036	ural',	d by		If Yes, Give Year or Dates:					Specify: 43	
7. 2. 2. 2. 2. 2. 2. 2. 2. 2. 2. 2. 2. 2.	"nat	Completed	15. Decedent's Education (Specify only highest grade co	mpleted)	(Give	dent's Usual Occup kind of work done DO NOT use retired	ation during most of working d)	'	6b. Kind of Business	
212	Hygiene.	lmo:	Elementary/Secondary (0-12)	College (1-4or 5+)	57	OCKER			GOVERNM	ENI
r a	al Hyg	ВеС	17. Father's Name (First, Middle, Last)	. 0			18. Mother's Name (			
urylan A	Mental Merital Markad c	To	AURELIO DE				SOLEDAD			
10 0	1 8 1 8 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		19a. Informant's Name/Relationship (Type,	Print)	19b. Maili	ng Address (Street	and Number or Rural I	Route Number,	City or Town, State,	Zip Code)
	Department of Health Department of Health Important: If itam 27 any injury or othar tr		20a. Method of Disposition		ace of Dispo	osition (Name of	Dar GUN Dar	te 2	Oc. Location - City or	Town, State
24 レンン Baltimore,	nent of Int. If its		1 ☐ Burial 2 ☐ Cremation 3 ☐ Remo	oval from State	-	natory or other place		2005 M	ARIVING GT	PHALODINE
24   Baltii	Department of the partment of the partment; If the partment; If any injury or once.		21. Signature of Funeral Service Licensee	11	25	2. Name and Ad	ss of Facility WAR	TULLOF	UNERALCHA	PEL, P.A.
2	Ded de d	2.7	michael & mary	ullo-	6	009 HARFO	DED ROAD B	ALTIMOR	E. MARYLAN	D 21014
7			23a. Part1. Enter the disease, or complication shock, or heart failure. List only one complications are complicated as the complete complete the complete co	ions that caused the death ause on each line.	. Do not en	ter the mode of dyir	ng, such as cardiac or	respiratory arre	st,	Approximate Interval Between Onset and Death
	hysician		Immediate Cause (Final disease or condition resulting in death)	Carcino	MA	DY /4	149 101	11/11	1015	JMU,
	/Medical Examiner			Due to (or as a consequ	ience of.					
-71		ler	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequ	uence of):					
2 4 3	ate be executed bhysician and the burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events							
50,	e exe sian ar urial-t	EX	resulting in death) Last	Due to (or as a consequ	ence of);					
68760,	I ne law requires mat me deam cermicate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	edicai	d.							
A 20	attending p	/Me		If yes, outcome of pregna					23d. Date of de	liverv
Box	death cer ne attendir ed for use	Physician/M	in the past 12 months?	1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de		Dectopic pregnancy Other (specify)	y		Month	Day Year
ν <b>σ</b>	inat ine de ed by the detached	hys	9 Unknown	9□ Unknown				· · · · · · · · · · · · · · · · · · ·		
S, F	es ing		Part II. Other significant conditions contrib	outing to death but not resu	alting in the c	inderlying cause giv	ven in Part I.			robably 4 Dunknown
A	w requires to been signe should be	eted	CON LIMONAL D	I DIONICI		<del></del>				
DE Apa	has the	Completed by						24a. Was an autopsy perform	24b. Were a prior to death?	utopsy findings available completion of cause of
		e Co	25. Was case referred to medical				26. Place of Death			\$ 2□No
	S S	To B	examiner?	pital:	ER/Outpatie	nt 3 DOA Ott	19r. 4 Nursing Home			ecity) HD5011A
ا مود	ding Phys h. After this funeral di		27. Mann of Death  1 atural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o				w injury occurred	11 pile
EL sion	death. ctor; Ai y the fu	catic	Accident investigation			M 1	Yes 2□No			/
CEL Division	l or Attan after deat Diractor: I in by the	Certification:	4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	ome, farm, st	reet, factory, office	28	31. Location (Str City or Town,	eet and Number or F , State)	iural Route Number,
0	urs urs aral		29a. Certifier 1 Certifying Physici	an: To the best of my kno	wledge, dea	th occurred at the ti	me, date and place, ar	nd due to the ca	use(s) and manner a	s stated.
17	To tha Hosi within 24 ho To tha Fund completely f	edical	(Check only 2 Medical Examiner one)	On the basis of examination and manner stated.	tion and/or in	estigation, in my	opinion, death occurred	d at the time, da	ite and place, and du	e to the cause(s)
	To tha within 2 To tha complet	Š	29b. Signature and title of certifier	11.0110		29c. Licens	se number	29	d. Date signed (Mon	th Day, Year)
	4		JAMW NI MA	MUMU			2012		4/20	149
	9		30. Name and address of person who owner	pleted cause of death (Item	23a) (Type	Print)	THE B	tho	1/1/2	1918
	Sta	ate	31. Date filed (Month, Day Year)	32. Registrar's Signa	ture of	woll !	u pa	114)	114 01	70
	Regist		31. Date filed (Month, Day Year) APR 2 6 2005	Charles St.	4000	<b>シ</b>				

amend Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrat Certificate of Death Reg. No: 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** (Obert Edwards 52P 2005 APri 3 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** oF HOSPITAL BAITIMOre BAITIMORE CIT If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign
 Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** 1**%** M 2□ F Months Days Hours Min. 219-30-0901 Yrs. Director Man Usual Residence of Decedent 10b. County 10c. City. Town or Location 10d. Inside City Limits 10a, State other traumatic event, the Medical Examiner must be nutified at Baltimore 1 √Yes 2 No Be Completed by Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 360 12. Was Decedent Ever in U.S. Amed Forces? 1 Yes 250 No If Yes, Give ( Year or Dates: 21216 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Specify: Black 1 ☐ Yes 2 1 No Specify: 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) aboren 18. Mother's Name (First, Middle, Maiden Sumame) Maryland 17. Father's Name (First, Middle, Last) Edward > 5C ျှ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 260 item 27 Man UVG Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory, or other place) Date 20c. Location - City or Town, State permit. Pages Department of Important: If it any injury or o ō 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) en mount 2005 (rem 21. Signature of Funeral Service License ce arl 21217 701 ulloh 23a. Part1. Enter the disease, or complications that dused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician SEPTIC Severe Stadrome disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine anding physicien and use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): 68760 Physician/Medical Box IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No ō Month Dav Year 4 Pregnant at time of death 5 Other (specify) P.O. | 9 Unknown Š signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. Be Completed by 3 Probably 4 Dinknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an certificate has autopsy performed 2 ₩0 1 Yes 2 No To the Hospital or Attending Physician: funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 ☐ Yes 2 ☐ No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending death. investigation 1 Tes 2 Accident filled in by the Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medicai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. npletely (Check only one) within 2 29d. Date signed (Month, Day, Year) 29b. Signature and tytle of certifier 29c. License number Carlo & Duffel APr. 1 23 2005 RES-000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1-0 BAITEMON SINAI HOSPITAL 31. Date filed (Month, Day, Year) APR 2 6 2005 32 Registrar's Signature State Registrar

Rober

					ander and a fill a life a mail A	-		
			For State	State of Maryland / Dep		nentai Hygier	าย กกร	11.01.5
			Registrar		ertificate of Death	Reg. I	46: 000	14040
	Physici	an	Decedent's Name (First, Middle, Last	1. Adam		2. Date of Death Month	Day Year	3. Time of Death
	/Medic	al	Lucia	W. Caeky	T	4-2		3.50 AM
7	Examin	er	4a. Facility Name (If not institution, give	/ / )	4b. City, Town, or Location of Death	1	4c. County of Death	
			5. Social Security Number 6. Se	x 7. Age (In yrs. last birthday	) If Under 1 Year If Under 24 Hrs.	i	BALTIM	
	Funeral Director			M 2 F 7. Age (III y/s. last birtiday	Months Days Hours Min.	8. Date of Birth (Month, Day, Yea	ar) 9. Binn	nplace (State or Foreign untry)
		-	Usual Residence of Decedent	14		y-30-7	2 300	th America
	yland		10a. State 10b. County	10c. City, Town or L	ocation			10d. Inside City Limits
	e-f s	ctor	MD Baltin	we !	OWSON			1 ☐ Yes 2 No
	or 28	)ire	10e. Street and Number		10f. Zip Code	10g. (	Citizen of What Co	untry?
	23e	<u>a</u>	7001 D. Chai	cles St.	21204		USA	
	tems	Jue	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White	
36	s afte	Ϋ́	1 Never Married 2 Married 3 12 Widowed 4 Divorced	1 ☐ Yes 2 M/No If Yes, Give	Allyn Ollah Constal		Specify:	nito
5-0036	within 72 hours after death with the Maryland ene. than "natural", or items 23e or 28e-f show ta Madical Exeminer must be mulified at	Completed by Funeral Director	15. Decedent's Edi	Year or Dates:		mbian	Kind of Duning	111
215	in 72 "na ledic	olet	(Specify only highest grad	le completed) (Giv.	edent's Usual Occupation e kind of work done during most of work DO NOT use retired)	ing 160.	Kind of Business/I	ndustry
212	l with lene.	mo	Elementary/Secondary (0-12)	College (1-4or 5+)	memaker		ww hon	10
	Hygid other	a	17. Father's Name (First, Middle, Last)			e (First, Middle, Maid		<u> </u>
lar	ould be Mental arked o	To B	Alhorto U	Jarnier	Blanc	a Cuac	los	
Maryland	2 shou and M Is mai	100	19a Informant's Name/Relationship (T	vpe, Print) 19b. Mai	ling Address (Street and Number or Ru			ip Code)
	1 and 2 Health a lam 27 li		Esther Dibo	s-daug. 230	akcidge (+ lu	thory.lle	MO 2	1093
ore.	es 1 a of He of He litam		20a. Method of Disposition	20b. Place of Disp cemetery, cre	position (Name of ematory or other place)	Date 20c.	Location - City or 1	Town, State
Ĕ	Page nent int; ii		1 ☐ Burial 2 ☐ Cremation 3 ☐ I 1 ☐ Donation 5 ☐ Other (Specify,	Evans Fund	exal Crapel - 11-2	2-05 F	DIOST H	11 MD
Baltimore	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene. Important: If item 27 is marked other than "naturat, or items 23e or 28e-f show any injury or othar traumatic event, it a Madical Examinat must be notified at ODGe.		21. Signature of Funeral Service Licens	iee 2	22. Name and Andress of Facility 2325	Delceo Ti	monium i	no 21093.
<u> </u>	82 5 8		Kimberly U.	4 to 10 (1) 11	FHCE FUL ALTERNA	MYES FUNE	EALYCKE	MATION CIR.
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	light ins that raused the death. Do not en	nter the mode of dying, such as cardiac	or respiratory arrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Dementio	1			Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequence of):				
	LAGITITIES	_	Sequentially list conditions, if any, leading to immediate	b				
V	pe eq	al le	if any, leading to immediate cause. Enter or Jerying Cause (Disease or injury	Due to (or as a consequence of):				
V	be executed ician and burial-transit	Examiner	that initiated events resulting in death) Last	c				
760,	eath certificate be execu attending physician and for use as the burial-trar	calE						
687	ficate physis the			d				
Вох	nding ph	W	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnancy			23d. Date of deli	verv
m	death e atten	Ca	in the past 1A months? 1 □ Yes 2 □ No	4 Pregnant at time of death 5	☐ Ectopic pregnancy ☐ Other (specify)		Month	Day Year
0	by the	hys	9 Unknown	9□ Unknown				
ري ص	<ul> <li>requires that the death</li> <li>been signed by the atte</li> <li>should be detached for</li> </ul>	by Physician/Med	Part II. Other significant conditions co	ntributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacc	o use contribute to	the cause of death?
Records,	en sig	ed				1 🗆 Yes	2 □ No 3 □ Pro	bably 4 Dunknown
၁၁	law re as be 2 sho	ple				24a. Was an autopsy	24b. Were au	topsy findings available ompletion of cause of
Ä	The ate has page	Completed				performed?	death?	2 <del>2</del> No
Vital	Physician: The law this certificate has t ral director, page 2 s	Be (	25. Was case referred to medical examiner?		26. Place of Dea	Check only one)		
of V	ding Physician: h. After this certific funeral director,	2	1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatie	ent 3 DOA Other: 4 Landrsing H	ome 5 Residence	6 ☐Other (Spec	ify)
ū	fter fter	on:	27. Manner of Death  1 Patural 5 Pending	28a. Date of Injury (Month, Day Year) 28b. Time Injury	Work?	28d. Describe how in	jury occurred	
sio	Attanding I or death. actor: After by the funer	cat	2 Accident investigation 3 Suicide 6 Could not be		M 1 Yes 2 No			
Division	or Attendation	Certification:	4 Homicide determined	28e. Place of Injury - At home, farm, s building, etc. (Specify)	treet, factory, office	28f. Location (Street City or Town, Sta	and Number or Ru ate)	ral Route Number,
	pital ours surs seral	2	29a, Certifier 1/2 Certifying Phy	sician: To the best of my knowledge, dea	the course of the time date and place	and due to the private	/a\ aad =======	
	To the Hospital or Attandi within 24 hours after death. To the Funeral Diractor: A completely filled in by the fu	edical	(Check only 2 Medical Exam	iner: On the basis of examination and/or i and manner stated.	nvestigation, in my opinion, death occur	red at the time, date a	and place, and due	to the cause(s)
	ro th vithin ro th	Me	29b. Signature and title of certifier	4	29c. License number	29d. [	Date signed (Month	, Day, Year)
			Knye	ali Dio.	H0054421	1 4	-22-	.05
	h		30. Name and address of person who c	ompleted cause of death (Item 23a) (Type	a, Print)			
	3		Cyrus Asadi,	20E. Timonium	Print) 10054421	onium, N	10210	93
	Sta	te ar	31. Date filed (Month, Pay Year)  A R 2 6	32. Polistrar's Signature	1.00			

DHMH 17 Rev 1/2001

			T - For Stete Registrar	State of Mar	-	artment of H			iene eg. No.2 0 0 5	14046
	4.4		Decedent's Name (First, Middle, Last)	)				2. Date of Dear	th	3. Time of Death
	Physici /Medic		Isabelle D. Ecklot	Ef				April 23	B, 2005	8:42 P M
	Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or	Location of Death		4c. County of Deat	
			4925 Battery Lane			Bethes			Montgome	
	Funeral		5. Social Security Number 6. Se	x 7.Age( ∃M 2⊠TF	In yrs. last birthday)  O O Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day	Year) Co	hplace (State or Foreign
	Director		579-14-5446 Usual Residence of Decedent		92 Yrs.			Sept. 2	4, 1912 was	hington, DC
	yland		10a. State 10b. County	1	Oc. City, Town or Lo	cation				10d. Inside City Limits
	a-f st	ctor	Maryland Montgome	ry	Bethesda					1 ☐ Yes 2 No
	or 28	Olre	10e. Street and Number			10f. Zip Code	·	1	0g. Citizen of What Co	ountry?
	ath w 23a	Funeral Director	4925 Battery Lane			20814			United Sta	
	er de	nne	11. Marital Status	12. Was Decedent Ev Armed Forces?	er in U.S. 13. \	Was Decedent of Hi f Yes, specify Cuba	ispanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit	
36	rs aff	by F	1 Never Married 2 Married  3 Widowed 4 Divorced	1 ☐ Yes 2 No If Yes, Give Year or Dates:		1□Yes 2X No	Specify:		Specify: Wh	ite
Maryland 21215-0036	within 72 hours after death with the Maryland ene. than "naturel", or Items 23a or 28a-f show fre Modeal Examiner must be notified at	ted	15. Decedent's Edu	ıcation	16a. Deced	dent's Usual Occupa	ation		16b. Kind of Business/	
215	hin 72	Completed	(Specify only highest grad Elementary/Secondary (0-12)	le completed) Collège (1-4or 5+)	life. I	kind of work done of DO NOT use retired	during most of work )	ing		,
7	giene grene er the	Ho	12			emaker			Own Home	
p	be file tal Hy d oth	Be (	17. Father's Name (First, Middle, Last)				18. Mother's Nam	e (First, Middle, I	Maiden Surname)	
<del>Z</del>	ould to Ment	2	Rene Dagneaux		-			ne Kaufi		
Mar	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel", or Items 23a or 28a-f show appringing or other traumetic event. The Marical Examiner must be nuffilled at ODGs.		19a. Informant's Name/Relationship (T)						, City or Town, State, 2	
e,	1 and Health em 2 ther		James C. Eckloff/S	on	20b. Place of Dispo	1-2-			l, Virginia 20c. Location - City or	
altimore,	ages nt of t: If it		1 X Burial 2 ☐ Cremation 3 ☐ F		cemetery,_cren	natory or other place	θ)   Apri	1 28,	ALL THE STATE OF T	
≣	artme ortane injury		'4 □ Donation 5 □ Other (Specify)  21. Signatur of Funeral Service License		Gate of I Cemet	ery Name and Address	2005		Silver Spr	neral Home/
Ba	Depril Imp		1 Vuiel E.	,	100803 Be	thesda-Ch	nevy Chas	e, Inc.	7557 Wisco	nsin Avenue
			23a. Part1. Enter the disease, or compl shock, or heart failure. List only o	ications that caused th						Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition		sclerotic	Cardiovs	ascular D	icasca	ma di Adrida	Onset and Death Years
	/Medical		resulting in death)	a	consequence of):	- Cararova	ibcular D	136436		rears
	Examiner		Sequentially list conditions,	b						
V	ed isit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a c	sonaduenca oi).					
V	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the buriat-transit	хап	that initiated events resulting in death) Last	c.  Due to (or as a c	consequence of);					
8760,	icate be ex physician s the buria	dlcal E		,	. ,					
687	ificate g physias the	0		U						
Вох	leath certifica attending ph I for use as t	Physiclan/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of 1 Live birth 2		Totorio assenza			23d. Date of del	ivery
<u>.</u>	ne deat the atte	sicla	in the past 12 months? 1 ☐ Yes 2 🔀 No	4☐Pregnant at tin		]Ectopic pregnancy ] Other <i>(specify)</i>			Month	Day Year
P.O.	that the design the detached	Phys	9 Unknown							
	res tha igned be de	by	Part II. Other significant conditions con Hypertension	ntributing to death but	not resulting in the ui	nderlying cause give	an in Part I.		pacco use contribute to	
orc	w requir	Completed	nypercension					1 1 76	es 2∭INo 3∏Pr	obably 4 Unknown
3ec	e law has b	nple						24a. Was a autops	y prior to d	topsy findings available completion of cause of
a F	ticien: The certificate ha							perform 1 Tes 2	ned? death? 2X No 1 ☐ Yes	2 🗆 No
Ħ	Attending Physicien: r death. ector: After this certifica by the funeral director. p	Be c	25. Was case referred to medical examiner?  1   Yes 2   No	lospital:	. □ = D = D = D = D = D = D = D = D = D =	• 3□ DOA Othe	26. Place of Deat			
Division of Vital Records,	Physic this seal of	. To	27. Manner of Death	1 Inpatient	28b. Time of	I JU DON	4   Nuising no		ence 6 Other (Spec	cify)
on	nding F ith. :: After e funera	atlor	1 X Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Y	'ear) Injury		r? Yes 2 □ No			
VIS		ifica	3 Suicide 6 Could not be determined	28e. Place of Injury	- At home, farm, str	eet, factory, office			reet and Number or Ru	ral Route Number,
	tal or A s after al Dire ed in by	Certification;	4 - Tombide	building, etc.	(Зр <del>о</del> сну)			City or Towr	, State)	
	Hospital 14 hours Funeral tely filled	edical	29a. Certifier Check only 2 Medical Exemi	sicien: To the best of a	my knowledge, death	occurred at the tim	e, date and place,	and due to the ca	ause(s) and manner as ate and place, and due	stated.
	To the Hospital or within 24 hours after To the Funeral Dir completely filled in	Medi	one)	and manner state	d.					
	To To con	-	29b. Signature and title of certifier	- LW. W.		29c. License	5236		9d. Date signed (Monti	
•							0 2 3 0	A	pril 25, 2	005
	8		30. Name and address of person who co	s. M.D. 1	11-25 Rock	ville Pik	ce. #211	Rockvi1	le, Maryla	nd 20852
	Sta	te	31. Date filed (Month, Day, Year APR	9 6 32 A 60 strar's	s to ature	A Const	<i>U</i> ",	11001111	,ry_a	
	Registr		MIN	20 2000	reconstruction	1				

			For State Registrar		of Maryland	l / Depa	artment of rtificate of	Health a	and M	•		•	14047
	Physici	an	1. Decedent's Name (First, Middle,		11.11					2. Date of De		Yeer	3. Time of Death
	/Medic			Pau1	Clifford	l Esc	hbach			April	18,	2005	7:44 P M
	Examin	er	4a. Facility Name (If not institution,				4b. City, Town,		of Death		1	County of Death	
	-		Shady Grove Ad  5. Social Security Number	o. Sex	7. Age (In yrs. Ia	st birthday)	Rocks		24 Hrs.	8 Date of Bi		ontgome	Dy place (State or Foreign
	Funeral Director		217-66-2265	1 € M 2 □ F	51	Yrs.	Months Days		Min.	8. Date of Bi (Month, D. October	av. Year) 2. 195	3 Mary	Land
	D		Usual Residence of Decedent										
	arylar show		10a. State 10b. County		10c. City,	Town or Lo	ocation						10d. Inside City Limits
	8e-f	ecto	Maryland Montgo	omery		Derwo				-			1 ☐ Yes 21 No
	a or 2	급	10e. Street and Number 7312 Blanchard	Drivo			10f. Zip Code	355				en of What Cou ed State	•
	eath	eral	11. Marital Status		edent Ever in U.S	. 13.			igin? (Sn	ecify Ves or N		4. Race - Ameri	
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours efter death with the Maryland Department of Health and Mental Hyglene. Importent: If item 27 is marked other then "natural", or items 23a or 28e-f ehow may highly or other treumatic event, I're Medical Examiner hast be notified at once.	by Funeral Director	1 ☐ Never Married 2 ☑ Marrie 3 ☐ Widowed 4 ☐ Divorced	Armed F	orces? 2 <b>∑</b> No ive		Was Decedent of If Yes, specify Cu 1 ☐ Yes 2 🎇 No			Rican, etc.)		Black, White, Specify: Wh:	etc.
9	72 hor	Completed	15. Decedent' (Specify only highest	s Education		16a. Dece	dent's Usual Occi	pation	et of work	ina		d of Business/In	,
21	thin 7	nple	Elementary/Secondary (0-12)	College	(1-4or 5+)	life.	kind of work don DO NOT use retir	ed)		ing			ospatial-
21	filed wi Hyglen other th			5+		Marine	Safety Da				1		e Agency
Maryland	ntal H ed ot	To Be	17. Father's Name (First, Middle, L							e (First, Middle	e, Maiden S	Su <i>mame)</i>	
Ž	should be find Mental has marked of	۲	Robert Anthony  19a. Informant's Name/Relationsh			19h Maili	ng Address (Stree		da Cu		her City or	Town State 7ii	Code)
Z	nd 2 s lith ar 27 is		Barbara Locke				Blanchar						
ē,	s 1 and 2 f Health item 27 I		20a. Method of Disposition		20b. Pla		sition (Name of matory or other pl			Pate 25,		cation - City or To	
Ë	Pages nent of I ent: If its iry or o		1 🕅 Burial 2 □ Cremation  1 4 □ Donation 5 □ Other (Sp		Julian		Gemete:		20		Germ	antown,	Maryland
Baltimore,	permit. Departm Importe any inju	1	21. Signature of Fun ral Service L	icensee	MO:	Ro 130530	Name and Add Dert A. P	ress of Facili umphrey	Fune	ral Home	/Rocks	ville, Inc	
			23a. Part1. Enter the disease, or shock, or heart failure. List of	complications that	caused the death.							, , , , , , , , , , , , , , , , , , , ,	Approximate Interval Between
	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions.	Due to	yocardia o (or as a consequ	ence of):	rction						Onset and Death
	ed sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to	(or as a consequ	ence of):							
	rate be executed physician and the burial-transit	xan	that initiated events resulting in death) Last	c	(or as a consequ	ence of):							
8760,	e be e siclar e buri	cal E	1	L a									
9	g phy as the	ed											
P.O. Box	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physiclan/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 Live	utcome of pregnar birth 2 Tetal gnant at time of de nown	death 3[	Ectopic pregnan Other (specify)	су			2	3d. Date of deliv Month	ery Day Year
	s that ned b	by Pr	Part II. Dther significant conditio	ns contributing to	death but not resu	Iting in the u	nderlying cause o	iven in Part	l.	23e. Did	tobacco us	se contribute to t	the cause of death?
Records,	w requires been sig should b	ed b								1 🗆	Yes 2	]No 3∏Prol	bably 4 XUnknown
000	aw re	Completed								24a. Wa		24b. Were auto	opsy findings available
R	The I	mo:								perf	opsy ormed? 2 X No	death?	ompletion of cause of 2 No
Vital	ysicien: The law is certificate has b director, page 2 s	Be C	25. Was case referred to medical examiner?					26. Plac	e of Deat	h (Check only			
of V	Physic this co	2	1X Yes 2 No	_			IL 3 DOA		ursing Ho			Other (Speci	fy)
n C	dlng F h. Attern tunera	on:	27. Manner of Death 1   Natural		of Injury nth, Day Year)	28b. Time o Injury	l W		101-	28d. Describe	how injury	coccurred	
isio	r Attending Physicien: er death. rector: Atter this certifics by the funeral director. I	Icat	2 Accident investig 3 Suicide 6 Could n	ot be	e of Injury - At hor	mo form of		]Yes 2□	No	28f Location	(Street and	Mumber or Pur	al Route Number.
Division	after after I Direct	Certification:	4 ☐ Homicide determi	ned 200. Flat	ding, etc. (Specify,	ne, rami, si	reet, factory, offici	Ð			own, State)		ar noute Number,
	To the Hospitel or Attendwithin 24 hours after death To the Funerel Director:	edical C	29a. Certifier 1 Certifying (Check only one) 2 Medical B	g Physician: To the Examiner: On the and ma	ne best of my know basis of examinati nner stated.	vledge, deat on and/or ir	h occurred at the vestigation, in my	time, date a	nd place, ath occur	and due to the red at the time	cause(s) a date and	and manner as s place, and due t	stated. o the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier			^	29c. Lice	nse number		میسی	29d. Date	signed (Month,	Day, Year)
	.6		> 5.	)cyan	n N	4)		005	7	135	H	00:11	8, 2005
	10		30. Name and address of person v								1		1
			Sunil Saxena, M		l Medica		ter Driv	e, Roc	kvi1	le, Ma	rylan	d 20850	
	Sta Registi		31. Date filed (Month, Day, Year)	32.	Registrar's Signat	ure	1. 1.	1. 1					
DH	IMH 17 Rev 1/2			PR 2 6 2	005		1. has						
-1			•				-						

ORIGINAL

		-	For 1 - State Registrer	State of Marylan		rtment of H		ntal Hygie	2000	14048
	Physici /Medic		1. Decedent's Name (First, Middle, Last	ster			2	Date of Death	al acc	3. Time of Death
si .	Examin		4a. Fecility Name (If not institution, give	street and number)	sotal	4b. City, Town, or	Location of Death	City	4c. County of Deat	h
	. Funeral Director		X4.1-20-1412		fast birthday) 13 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. 8 Hours Min.	Date of Birth Month, Day Y	9. Bin 931 S. C	hplace (State or Foreign puntry) AROU/DA
	Maryland 1 show	or	Usual Residence of Decedent  10a. State  10b. County		y, Town or Lo	cation		-		10d. Inside City Limits
	with the	Direct	100. Street and Number 301 McMechen St		THOLE	10f. Zip Code			. Citizen of What Co	ountry?
936	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "neturel", or Items 23a or 28e-f show entry injury or other treumetic event, the Medical Eracinal retriest collidated at Once.	by Funer	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces?  1 Yes 2 No If Yes, Give Year or Dates:	1	Vas Decedent of H	lispanic Origin? (Specian, Mexican, Puerto Ri	tv Yes or No-	14. Race - Ame Black, Whit Specify: 6/6	
21215-0036	2 should be filed within 72 hours att and Mental Hygiene. Is marked other then "neturel", or eumetic event, the Medical Erami	Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12)		(Give	lent's Usual Occup kind of work done DO NOT use retired	during most of working d)	7	b. Kind of Business	
Maryland 2	uld be filed Mental Hygir rked other tic event, I	To Be C	17. Father's Name (First, Middle, Last) Henn Rice		d=		18. Mother's Name (	First, Middle, Ma	iden Sumame)	
	and 2 should ealth and Men n 27 Is marke ler treumetic		19a. Informant's Name/Relationship (T. Patricia Foster - C	aughter	19b. Mailir	ng Address (Street Orchûrd	and Number or Rural. St. Balto		City or Town, State, 2 91301	Zip Code)
Baltimore,	Pages 1 and nent of Healt sut: If item 2 arts or other		20a. Method of Disposition  1 Burial 2 Dependation 3 1  4 Donation Dother (Specify,	Removal from State	Place of Dispo Semetery, cren Stenn	sition (Name of natory or other place Cemeter	Da 4-26-		c. Location - City or altimore	
Balti	permit. Pag Department Importent: eny injury o		21. Signature of Pineral Service I cens	nel	Ga	Name and Addre		-	ass Baito.	
	Physician		23a. Parl . Eptey the disease, or comp shock, or beart failure. List only of Immediate Cluse (Final disease of condition	lications that caused the deat ne cause on each line.		. )	ng, such as cardiac or	respiratory arres	t,	Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequence of the control of the c	juence of):	al Fa	lure			
	and Il-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequence Contact	1 70	she ?	0100			
8760,	ate be executed hysician and the burial-transit	licai	resulting in death) Last	Due to (or as a conseq	juence of):					
.O. Box 68	he death certificate be executed the attending physician and ched for use as the burial-transi	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of o	ıl death 3□	Ectopic pregnancy	у		23d. Date of de Month	livery Day Year
Δ.	law requires that the de as been signed by the 2 should be detached	by	Part II. Other significant conditions co	ntributing to death but not res	ulting in the u	nderlying cause giv	ven in Part I.			o the cause of death?
of Vital Records,	icien: The law req certificate has beer rector, page 2 shou	Completed						24a. Was an autopsy performs	24b. Were an prior to death?	utopsy findings available completion of cause of
Vital	Physicien: this certifica ral director, p	Be	25. Was case referred to medical examiner?	Hospital:		Ott	26. Place of Death	(Check only one)		
n of	ding Phys h. After this funeral dir	on: To	1 ☐ Yes 2 📆 No  27. Manner of Death 1 🛣 Natural 5 ☐ Pending	1 Mainpatient 2 ☐ 28a. Date of Injury (Month, Day Year)	ER/Outpatier 28b. Time o Injury	IL 3LI DOM	4   Nursing Hom	e 5 Residen 3d. Describe how	ce 6 Other (Sperinjury occurred	cify)
Division	or Attending after death. Director: After in by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Speci			Yes 2 □No	Bf. Location (Stre City or Town,	et and Number or R State)	ural Route Number,
	Hospitel 4 hours 7 unerel tely filled	edical Ce	29a. Certifier 1 Certifying Ph (Check only one) 2 Medicel Exert	vsician: To the best of my kno iner: On the basis of examina and manner stated.	owledge, deat ation and/or in	h occurred at the til vestigation, in my o	me, date and place, ar opinion, death occurre	nd due to the cau d at the time, dat	se(s) and manner as e and place, and due	s stated. e to the cause(s)
	To the within 2 To the complet	Med	29b. Signature and little of certifier	(Dwn Ly		29c. Licens	se number	290	d. Date signed (Moni	th, Day, Year)
	5		30. Name and address of person who	completed cause of death (Itel	m 23a) (Type,	Print);	70 /	, (	HALL G	(200)
	St	ite	31. Date filed (Month, Day, Year)	32. Registrar's Sign	ature ,	Clo 1	1 langla	nd Ue	neral	1 Toppital
	Regist		APR 2 6 ZUUD	produce Si.	Agen	W				

		•	State of Maryland / Dep	eartment of Health and Mertificate of Death		ene 005	14049
	g		Decedent's Name (First, Middle, Last)		2. Date of Death		3. Time of Death
	Physicia /Medic		Ethel Muncy Freeland		April	24 2005	6:15 Pм
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	)
			Presbyterian Home of MD	Towson		Baltimo	
	Funeral Director		5. Social Security Number 6. Sex 1 $\square$ M 2 $\square$ F 7. Age (In yrs. last birthday 101 Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, Y- August 21	9. Birth Co. 1903 II	place (State or Foreign Intry) Linois
	pu .		Usual Residence of Decedent         10c. City, Town or I           10a, State         10b. County         10c. City, Town or I	ocation			10d. Inside City Limits
	fanyla sho	ក	Maryland Baltimore Towson	20041011			1 ☐ Yes 2 ☑ No
	288-	ect	10e. Street and Number	10f. Zip Code	100	2. Citizen of What Cou	
	th with 23a or	al Di	400 Georgia Ct.	21204	"	United Sta	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Importent: If Item 27 is marked other than "neturel", or Items 23a or 28a-f show any injury or other treumatic avent, the Medical Examinal must be notified at once.	y Funeral Director	11. Marital Status  1  Never Married 2 Married  3  Wildowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1  Yes, 2  No If Yes, Give Year or Dates:	. Was Decedent of Hispanic Origin? (Spulf Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White Specify:	
8	thou sture	ed	15. Decedent's Education 16a. Dec	edent's Usual Occupation	16	Sb. Kind of Business/I	
Maryland 21215-0036	within 72 ine. ihan "ne e Medi	Completed by	Elementary/Secondary (0-12) College (1-4or 5+)	re kind of work done during most of worki DO NOT use retired)	ing		,
9	filed v Hygie ther t		17. Father's Name (First, Middle, Last)	memaker  18. Mother's Name	e (First, Middle, Ma	own home	
/lan	uld be Mental Irkad o	To Be	Elihu Muncy	Ora May		,	
Mary	t 2 sho h and t f is me			ling Address (Street and Number or Rura Belmont Forest Ct.		City or Town, State, Z nonium, MD	
	f Healti f Healti ltem 2	1	20a. Method of Disposition 20b. Place of Dis			oc. Location - City or	
altimore,	Page ment o ent: If lury or		1 ABurial 2 Cremation 3 Hemoval from State	dge Cemetery Apr. 2	27,2005	Pikesville	e, Maryland
Balt	permit. Depart Import any inj once.		21. Signature of Funeral Service Licensee	<sup>22. Nam</sup> Mitchell-Wiede 6500 York Rd.	feld Fune Baltimo	ral Home, ore. MD 21	Inc. 1212
			23a. Part . Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line.	nter the mode of dying, such as cardiac	or respiratory arrest		Approximate Interval Between Onset and Death
)	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)  a. Due to (or as a consequence of):	andiel Infanction			one des
	Examiner		Sequentially list conditions, b.				
	ted nsit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.				
oʻ	cate be executed physician and the burial-transit	Exar	that initiated events c.  Due to (or as a consequence of):				
8760,	cate be ohysicia the bu	dicai	d				
9		/Me	IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of deli	verv
.O. Box	that the death certified by the attending of	Physician/Me		☐ Ectopic pregnancy ☐ Other (specify)	<del>*************************************</del>	Month	Day Year
ds, P	9 E	ρ	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		cco use contribute to	the cause of death?
Vital Records,	The law requirate has been spage 2 should	Completed			24a. Was an autopsy performe	prior to death?	topsy findings available completion of cause of
ta		a	25. Was case referred to medical	26. Place of Deat	1 ☐ Yes 2. h (Check only one)		2 <b>/3</b> No
$\leq$	S D	To B	examiner? 1 ☐ Yes 2 KNo  Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpati	Other		ce 6 Other (Spec	cify)
on of			27. Manner of Death  1 Natural 5 Pending 2 Accident investigation  28a. Date of Injury (Month, Day Year)  28b. Time Injury		28d. Describe how	injury occurred	
Division	To the Hospitel or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune.	ertification:	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	28f. Location (Stre City or Town,	et and Number or Ru State)	ral Route Number,
	To the Hospitel or At within 24 hours after or To the Funeral Direct completely filled in by	edical C	29a. Certifier  (Check only one)  12 Certifying Physician: To the best of my knowledge, de 2 Medicel Exeminer: On the basis of examination and/or and manner stated.	ath occurred at the time, date and place, investigation, in my opinion, death occur	and due to the cau red at the time, date	ise(s) and manner as e and place, and due	stated. to the cause(s)
)	To the within To the comp	W	29b. Signature and title of certifier  Attention mo	29c. License number 037016		Date signed (Month	-
/	101		30. Name and address of person who completed cause of death (Item 23a) (Typ  Lench m. Great, G70/  31. Date filed (Month Day Year)	e. Print) N. (Geoles H., Sa.		•	
•	Sta Regist	ate rar	31. Date filed (Month, Day, Year)  32. Pogistrar's Signature	Garle			
			The second secon				

			1 - For State Registrar	State of Maryland /	-	nt of Health and te of Death	Mental Hygie	6000	14050
	Physici /Medio		Decedent's Name (First, Middle, La	st)		Faulk	2. Date of Death  Month	Day 2005	3. Time of Death
	Examir Funeral Director		4a. Facility Name (If not institution, given by the second of the second	LOPICINS HOSPIT	17) BG	Town, or Location of Deal The More of Type of	B. Date of Birth	4c. County of Death	hplace (State or Foreign
	D	0	Usual Residence of Decedent  10a. State 10b. County	10c. City, Tov	vn or Location		1-0-	7 2 1001	10d. Inside City Limits
	the Mary 28a-f sh notified	Director	10e, Street and Number	Bal.	time!	COde	10g	. Citizen of What Co	1
	eath with	Funeral Di	1718 N. Aisgu	12. Was Decedent Ever in U.S.	13. Was Dece	2/202 Ident of Hispanic Origin? (S	Specify Yes or No-	USA 14. Race - Ame	rican Indian.
920	ours after d rai', or itan Examiner	þ	iXNever Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 ☐ o If Yes, Give Year or Dates:	If Yes, sp	ecify Cuban, Mexican, Puèr 2	to Rican, etc.)	Specify: R	slack
21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland f Hauth and Mantal Hygiene. itam 27 is marked other than "natural", or itams 23s or 28s-f show other traumatic event, the Modical Examinations the notified at	Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)		a. Decedent's Usi (Give kind of w life, DO NOT	ork done during most of wo	orking 16	b. Kind of Business/	industry
	2 should be filed within and Mantal Hygiene. is markad other then aumatic avant, the M	To Be Co	17. Father's Name (First, Middle, Last) Harcon J Fo	y u/K	9	18. Mother's Na	me (First, Middle, Ma	iden Sumame) SCOH	-
, Maryland	1 and 2 shou Haalth and M tam 27 is mar othar traumat	_	19a, Informant's Name Relationship	ant (daughter)	3529	S (Street and Number or A Parklaw)	ural Route Number, C	salto.M.	021213
Baltimore,	m O		20a. Method of Disposition  1 ★Burial 2 □ Cremation 3 L  4 □ Donation 5 □ Other (Speci	Removal from State	of Disposition (Na ery, crematory or MON+/	eme ton 4	Date 20		Town, State  J, N.C.  Dices P.A.
Balt	permit. Page Department important: if any injury o		21. Signature of Funeral Service Lice	v Grue	Variation Variation	hadres of Facility 5 Uol	d. Bal	to MA	V2/2
	Ph <sub>y</sub> sician		23a. Part1. Enter the disease, or conshock, or heart failure. List only immediate Cause (Final disease or condition	<b></b> . • .	Hemorrh		c or respiratory arres	,	Approximate Interval Between Onset and Death
	/Medical Examiner	er	resulting in death)  Sequentially list conditions, if any, leading to immediate	b. Due to (or as a consequence  Due to (or as a consequence	of):	,-			years
8760,	cate be executed physician and the burial-transit	ai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	C Due to (or as a consequence	of):				
P.O. Box 687	ne death certifi tha attending hed for usa as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1 \( \text{Live birth} \) 2 \( \text{Fetal death} \) 4 \( \text{Pregnant at time of death} \) 9 \( \text{Unknown} \)	h 3 DEctopic			23d. Date of del Month	ivery Day Year
	uires that the signed by the signed by the detaction of the detaction of the signed by	by	Part II. Other significant conditions	contributing to death but not resulting	in the underlying	cause given in Part I.			the cause of death?
Records,	o <u>- 9</u>	Completed					24a. Whas an autopsy performe	prior to	utopsy findings available completion of cause of
Vital	ician: Th certificata ector, pag	Be	25. Was case referred to medical examiner?				eath (Check only one)		
of V	Physician: this certific ral director,	2	1 ☐ Yes 2 K No	Hospital: 1 Inpatient 2 ER/C			Home 5 ☐ Residen		cify)
Division o	Jing After fune	Certification;	27. Manner of Death  1 XNatural 5 Pending 2 Accident investigation 3 Suicide 6 Could not	(Month, Day Year)	Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how	et and Number or Ri	ural Route Number.
Div	after Dira		4 ☐ Homicide determined	building, etc. (Specify)  hysician: To the best of my knowled			City or Town,	State)	
	To the Hospital within 24 hours To the Funaral completely filled	edicai		miner: On the basis of examination a and manner stated.					
	To the Ly within 2. To the Complet	Me	29b. Signature and title of certifie		2	9c. License number		d. Date signed (Mont	
) ,	1		1	MD		RES-000	F	April 22,	2005
(	0'		30. Name and address of person who Juseph Dedrick Jo	rdon, MD, PLD 600 N	) (Type, Print)	ie Street Balti	more Maryla	nd 21287	
	St Regist	ate rar	31. Date filed (Month, Day, Year)	2005 32. Figistrar's Signature	boot	j			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 1 1

			For State	State of Maryland				nd Mental Hy	giene	005	14051
	17		Registrar		Cert	ificate of	Death		Reg. No.		
	Physici	an	1. Decedent's Name (First, Middle, Last)	lliam F	idle			2. Date of De	Day	Year	3. Time of Death  (o:25 PM
1	/Medic	al	James Wi 4a. Facility Name (If not institution, give s			4b. City, Town, o	r Location of	Apri Apri	45.50	2005 unty of Death	-
	Examin	ier	11.0:10.00:1	1 1 1 1	nd.	Balt	1				
	Funeral		5. Social Security Number / 6. Sex	7. Age (In yrs. las		If Under 1 Year	If Under 24	Hrs. 8. Date of Bir	th	n/a 9. Birthi	place (State or Foreign
	Director		210-32-9537 <sup>1</sup> X	M 2□F 61	Yrs.	Months Days	Hours	Min. (Month, Da Jan 29,	1944	Penr	nty) nsylvania
	pun &		Usual Residence of Decedent  10a. State 10b. County	10c City	Town or Loca	ation					10d. Inside City Limits
	faryla sho	ŏ									1 ☐ Yes 2 🖾 No
	28e-1	Director	Maryland Baltimo  10e. Street and Number	re l	erry F	10f. Zip Code			10g Citizer	n of What Cou	
	aa or	<u></u>	3800 Wean Dr., uni	+ A		2123	6			USA	y.
	ms 2	era		2. Was Decedent Ever in U.S.	. 13. W			n? (Specify Yes or No Puerto Rican, etc.)		Race - Ameri	
9	or ite	by Funerai	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1		Yes, specify Cuba ⊐Yes 2⊠ No		Puerto Hican, etc.)		Black, White,	etc.
5-0036	72 hours after death with the Maryland haturel', or items 23a or 28e-1 show disal Exama her must be molified at	d b	3 Widowed 4 Divorced	Year or Dates:					Sp	Wh:	ite
5-(	"natu	Completed	15. Decedent's Educ (Specify only highest grade	cation completed)	(Give k	nt's Usual Occup ind of work done O NOT use retired	during most o	of working	16b. Kind	of Business/In	ndustry
2121	within ene. than *	d L	Elementary/Secondary (0-12)	College (1-4or 5+) 04				entative	и.	ardware	<u> </u>
d 2	filed Hygir other ent,		17. Father's Name (First, Middle, Last)	υ	lanurac	.curing		s Name (First, Middle			
<u>a</u> n	should be and Mental I	To Be	James Willi	am Fidl	er, Sr		E-	velyn			
Maryland	s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hygiene. item 27 is marked other than "naturel", or items 23a or 28e-1 show other treumatic event, ite Modical Examinations in the notified at	Γ.	19a. Informant's Name/Relationship (Typ				and Number	or Rural Route Numb	er, City or To	own, State, Zij	Code)
_	and 2 ealth a n 27 is		Lorraine Marie Fi					t A, Perry	Hall,	, MD 2	21236
ore	ges 1 t of He If iten or oth		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Re	20b. Pla	ce of Disposi netery, crema	tion (Name of atory or other plac	ce) 4	/16/05	20c. Locat	ion - City or To	own, State
Ë	Pa Introduction		'4 Domition 5 ☐ Other (Specify)	Du1a:		lley Mer		lens	Timor	nium, M	Maryland
Baltimore,	permit. Page Department o Importent: If any injury or once.		1. Signature of Figure 1. Service Livense	Celet	22. Le	Name and Addre	ss of Facility	Home of Du	lanev	Valley	Inc.
	405 40		Bryan W. Clary		10	W. Pad	<u>onia R</u>	oad, Timon	ium, 1	1D 210	93
			23a. Part1. Enter the disease, or compli- shock, or heart failure. List only on Immediate Cause (Final	e cause on each line.	-			ardiac or respiratory a	rrest,		Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	cerepral		Intior	<u> </u>				3 days
	Examiner			Due to (or as a conseque		n					2000
		Jer	Sequentially list conditions, if any leading I immediate	Due to # r as a conseque	ence of:						20 415
	tificate be executed ig physician and as the burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	huperlin	<u>pider</u>	nia					20 yrs
0,	e exe ian ar urial-t	EX	resulting in death) Last	Due to (br as a conseque	ence of):				_		1
68760,	ate b	edicai									
	ding p	/Me	IF FEMALE:	3c. If yes, outcome of pregnance	CV.						
Box	that the death cert ed by the attendin detached for use a	Physician/M	in the past 12 months?	1☐Live birth 2☐Fetal d 4☐Pregnant at time of dea	death 3□E	ctopic pregnancy Other (specify)	У		230	. Date of delive Month	ery Day Year
0	at the de by the stached	ysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown	0,,	5 (101 (opcomy)					
σ.	faw requires that the as been signed by th 2 should be detache	by Pł	Part II. Other significant conditions con	tributing to death but not result	ting in the und	lerlying cause giv	en in Part I.	23e. Did t	obacco use	contribute to t	he cause of death?
Records,	v require: been sig should b	ed b						1 🗆	Yes 2□N	lo 3 Prot	pably 4 🖺 Unknown
ဝင္ထ	aw requis been 2 should	piet						24a. Was		4b. Were auto	opsy findings available impletion of cause of
	The fate had page	Completed						autoj perfo	rmed? 2 X No	death?	
ita	elcien: The faw certificate has b irector, page 2 s	Be (	25. Was case referred to medical examiner?					f Death (Check only of			
of Vital	Physicien: this certific ral director,	2	1 ☐ Yes 2 No		R/Outpatient	3□ DOA Oth	7	ing Home 5 Resi			5/)
n c	ding P h. After funera	Certification:	27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injur Wor	rk?	28d. Describe	now injury o	curred	
Division	ttendi death. ctor: A y the fu	icat	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - At hom	ne farm stree		Yes 2 No		Street and N	lumber or Ruc	al Route Number,
Div	after Dire	ertii	4 Homicide determined	building, etc. (Specify)	10, 141111, 31101	st, lactory, office		City or To	vn, State)	2.1.00.0771210	ar riodio rambor,
	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director.		29a. Certifier Certifying Phys	ician: To the best of my knowl	ledge, death	occurred at the tir	ne, date and	place, and due to the	cause(s) and	d manner as s	tated.
	n 24   he Fu pletely	Medical	(Check only 2 Medical Examination)	er: On the basis of examination and mariner stated.	on and/or inve	stigation, in my o	pinion, death	occurred at the time,	date and pla	ice, and due to	o the cause(s)
	To the To the Comp	Σ	29b. Signature and title of certifier	Hattelson		29c. Licens	e number		29d. Date s	igned (Month,	Day, Year)
	1		* Manual Constitution of the constitution of t	M DEUROLOGU I	reside	nt P	1580	)5	Apr	1 6	2005
	h		30. Name and address of person who co	mplete cause of dead (IV m 2	23a) (Type, P	rint)	- I - T	all	MA !=	0.74	0.1
			31. Date filed (Month, Day, Year)	USUN 225.	CIVEO	vie stri	et E	Balti Morz	IND	2120	/
	Sta	ite	ADD 9 C 20		Con	العظام					

ROSE Vinginia Gray  ROSE Vinginia Gray  45 Cav, Town or Location of Death  46 Cav, Town or Location of Death  47 Facility Name (if not institution, give street and number)  10 John A Hopkins Hoapital  5. Social Security Number  20 -09 -08 90  1 M 2 M F 90  1 Vis.  10 Cav, Town or Location of Death  8 Baltimore  N/A  10 John A Hopkins Hoapital  10 John A Hopkins Hopkins Hopkins Hopkins Hours Hopkins Hours Hours Hopkins  10 John A Hopkins Hoapital  10 John A Hopkins Hopkins Hopkins Hopkins Hours Hours Hopkins  10 John A Hours Hall Hours Hopkins  10 John A Hours Hall Hours Hopkins Hours Hopkins  10 John A Hours Hall Hours Hours Hopkins  10 John A Hours Hall Hours Hopkins Hours Hopkins  10 John A Hours Hall Hours Hopkins Hours Hopkins  10 John A Hours Hall Hours Hou		mend Item 26 per v		Certificate	of Death	2. Date of De		U J ]	ne of Death
TOTAL A CONTROL SEASON SEASON SEASON SEASON SEASON SPECIAL SEASON	cian	Decedent's Name (First, Middle, La.				Month		Year _	
Social Security Number   6.5 Max   7. Age (In yrx. lext birthology   11 United 1 Very   10 United 1 Very	dical				4h City Town or				51 PM
Social Section Numbers   6.5 acc   1 m AT   7.6 per for years and historically   University   Numbers   1 m AT   1 m A	iner		012-00-11				vo. county		
The companies of December   Continue   Con				st birthday) If Under 1 \	ear If Under 24 Hr	s. 8. Date of Bir	th		tate or Foreign
Use   Description of Description   100. College			Day office	Months   D	ays Hours Mir	Feb. 2	4. 1915	Mari	iland
Backland   NA						1 60. 2	1, 1,15		
The Series and Number   107. Zep Code   109. Citizen of What I Country?   109. Citizen of What I Country?   110. Zep Code   109. Citizen of What I Country?   110. Tap Code   109. Citizen of What I Country?   110. Tap Code   110. Tap Code		10a. State 10b. County	10c. City,	Town or Location					
15   N. Rabias Salas   12   Was Decederd Ever in U.S.   13   Was Decederd Ever in U.S.   14   White Salas   15   White Salas	ğ	Maruland N/A		Ва	ltimore			1/4	Yes 2 No
16 N. Robinson St.  11 Marie Status 11 Marie Status 12 Was Depodent Ever in U.S. 13 Was Depodent Repeat (Prior) (Specify Yes or No. 14 Read American Indian, Black, Winke, etc.) 19 Yes, Carlo 19 Yes,	i e			10f. Zip Co	de		10g. Citizen of W	Vhat Country?	
10   New Marind Status   12   Was Developed Even PLS   13   Was Developed of Report Corpor (Specify Ves or the Specific Orange of Specific Orang		416 N. Robinson S	St.		21224		и.	S. A.	
Security   Specific	Je.		12. Was Decedent Ever in U,S	i. 13. Was Decedent	of Hispanic Origin? ( Cuban, Mexican, Pue	Specify Yes or No irto Rican, etc.)	b- 14. Race Blac		an,
16a   December   Supervisor	7		1 ☐ Yes 2 X No If Yes, Give						
William Stansbury  Anna ALCS    William Stansbury   St	5	3 X Widowed 4 □ Divorced	Year or Dates:					Whit	e
William Stanbury  19. Informarts Name (pints, Mode), Last)  William Stanbury  19. Informarts Name (pints, Mode), Last)  William Stanbury  19. Informarts Name (pints)  Rosemantic Youngblood (Ghanddghtt) 322 N. Robinson St., Baltimore, Manyland 21214  20. Method Disposition (Pennsion 3   Chemoval from State 4   Donation 5   Chemation 5   Chematic 5	ete	15. Decedent's Ed (Specify only highest gra	ducation ade completed)	16a. Decedent's Usual C (Give kind of work of	ccupation lone during most of w	orking	16b. Kind of Bu	isiness/Industry	
William Stansbury    William Stansbury   Sansbury   San	g E		College (1-4or 5+)					Technic	
William Stansbury    Stansbury	Ŝ	U DIE S DITTO	1	Faci			Maiden Sumam		
19a. Informant's Name-Relationship (Type, Print)   19b. Mailing Address (Street and Number of Paral Route Number, City or Town, State, Zip Code)	Be							-,	
Board   Second   Se	9			40h Mailine Address (C				State 7in Code)	
20b. Place of Disposition (Name of 19 place)   20b. Place of Disposition (Name of 20 place)   20b. Place of Death (Check only one)   20b. Place of Death (Check only on									1001
Sequence of the contribute of the cause of									
22. Name and Address of Facility  23a Feff. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardac or respiratory arrest.  23a Feff. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardac or respiratory arrest.  Approximate fishing and the death of the d									
23a First. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.  23a First. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.  23a First. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.  23a First. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.  23a Coronary Artery Disease  Due to (or as a consequence of):  25a Quentially list conditions, and y leading to minedate Cause (Pisease or right)  25a Due to (or as a consequence of):  2		4 ☐ Donation 5 ☐ Other (Specil							
23a. Fight Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.    Approximate above, or heart failure. List only one ceuse on each line.   Approximate above, or heart failure. List only one ceuse on each line.		21. Signature of Funeral Servica Lica	nsee						
Sequentially list conditions.  Sequentially list conditions.  Consequence off:  Due to (or as a consequence off):  Due to		Van on		3331 Bre	hms Lane,	Baltimo	re, Mary	land 212	13
Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I.    Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I.   Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I.   Part II. Other eignificant conditions contribute to the cause of death   1	Ical Examiner	Cause (Disease or injury that initiated events	C						
24a. Was an autopsy performed?  24a. Was an autopsy performed?  24b. Were autopsy finding available prior to completion of cause of deeth?  1	Ψ.	resulting in death) Last	d					1	
24a. Was an autopsy performed?  24a. Was an autopsy performed?  24b. Were autopsy finding available prior to completion of cause of deeth?  1	sicia	Part II. Other eignificant conditions	contributing to death but not result	Iting in the underlying cau	se given in Part I.	23b. Did	tobacco use cor	ntribute to the ca	use of death
24a. Was an autopsy performed?  24b. Were autopsy finding available prior to completion of cause of deeth?  25. Was case referred to medical examiner?  26. Place of Death (Check only, one)  27. Manner of Death President Solicide (Month, Day Year)  28c. Injury at Work?  28d. Describe how injury occurred at the time, date and place, and due to the cause(s) and manner as stated.  29d. Describe how injury occurred at the time, date and place, and due to the cause(s) and manner as stated.  29d. Describe how injury occurred at the time, date and place, and due to the ca	V Phys	Diabetes n	nellitus Typ	e II		1	Yes 2□No	3 Probably	4 Unknow
25. Was case referred to medical examiner?    1						24a. Wa	s an autopsy ormed?	available completio	prior to on of cause
25. Was case referred to medical examiner?  1   Yes 2   No	E					1 🗆	Yes 2 No	1 ☐ Yes	2 🗆 No
1   Yes   2   No					26. Place of D	eath (Check only	one)		
27. Manner of Death 1 Naturel 2 \( \text{Accident} \) 3 \( \text{Suicide} \) 4 \( \text{Homicide} \) 28e. Date of Injury (Month, Day Year) 28b. Time of Injury M \( \text{Nort?} \) 1 \( \text{Yes} \) 2 \( \text{No} \) 28c. Injury at Work? 1 \( \text{Yes} \) 2 \( \text{Nort?} \) 28d. Describe how injury occurred  28d. Describe how	0	1 Yes 2 No	Hospital: 1 Inpatient 2 1	ER/Outpetient 3□ DOA	Other: 4 Nursing	Home 5	idenee 6 □Oth	er (Specify)	
2 Accident 3 Suicide 4 Homicide  29a. Certifier (Check only one)  29b. Signature and title of cartifier  29c. License number  29c. License number  29c. License number  29d. Date signed (Month, Dey, Year)  29d. Cartifier  29d. Date signed (Month, Dey, Year)  29d. Date signed (Month, Dey, Year)			28e. Date of Injury (Month, Day Year)	28b. Time of 28c Injury	Injury at Work?	28d. Describe	how injury occur	red	
29a. Certifier (Check only one)  29b. Signature and title of cartifier  29c. License number  29d. Date signed (Month, Dey, Year)  29d. Date signed (Month, Dey, Year)	1000	2 Accident investigation 3 Suicide 6 Could not be	pe 28e. Placa of Injury - At ho	me, farm, street, factory, o		28f. Location City or To	(Street and Numb own, State)	per or Rural Route	e Number,
29b. Signature and title of cartifier  29c. License number  29d. Date signed (Month, Dey, Year)  April 18th, 2005	erti		hysician: To the best of my know	viedge, death occurred at ion end/or investigation, in	the time, date and pla my opinion, death oc	ce, and due to the curred at the time	cause(s) and ma , date and place,	anner as stated. and due to the ca	ause(s)
Vanhelle 1, MD D56705 April 18th, 2005		(Check only 2 Medical Exa							
	edical	(Check only 2 Medical Examone)		29c. L	icense number		29d. Date signe	d (Month, Dey, Y	ear)
30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)	edical	(Check only 2 Medical Examone)	and manner stated.						
	edical	(Check only 2 Medical Example of Cartifier    Signature and title of cartifier   Wurhelle	and manner stated.	D D	56705		April	18th, 2	005

			For State Registrar	State of	Maryland		artment rtificate			and M	-	giene Reg. No.	00	5	14053	3
			Decedent's Name (First, Middle, La	ist)							2. Date of De	ath			3. Time of Death	
П	Physici /Medic		Dante Granito								April	Day 1 8		2005	10:52	o <sup>M</sup>
	Examin		4a. Facility Name (If not institution, gir	re street and numi	ber)		4b. City, T	Town, or	Location of	of Death				of Death		
			Renaissance Ga						svi				3al	timoı		
	Funeral Director		216-38-6647	Sex 7 1 <b>X</b> M 2 □ F	. Age (In yrs. Ia:		If Under	Days	If Under: Hours	Min.	8. Date of Bir (Month, Da Dec 1,	1913	3	9. Birthpi Count Fran	ace (State or Fore ry) CE	ign
	land		Usual Residence of Decedent  10a. State 10b. County		10c. City,	Town or Lo	cation							10	d. Inside City Lim	nits
	e-f sh	ctor	Maryland Baltimor	re	Cat	onsvi	lle								1 ☐ Yes 2 🔀 I	No
	3e or 28	i Dire	10e. Street and Number 709 Maiden Choice	Lane Ro	om 415		10f. Zip (							What Count State		
980	d within 72 hours after death with the Maryland Jene. Ir then "natural", or Items 23e or 28e-f show Its Modical Examiter mat be motified at	by Funeral Director	11. Marital Status  1 Never Married 2 Married 3 XWidowed 4 Divorced	12. Was Deced Armed Ford 1X Yes 2 If Yes, Give Year or Dat	ent Ever in U.S. es? !  \( \) No es:1950-5	1 1	Was Decede f Yes, speci	fy Cuban	spanic Ori , Mexican Specify:	gin? (Spe i, Puerto	ecify Yes or No Rican, etc.)	)-		ce - America ck, White, e y: Wh		
2-0	72 ho	eted	15. Decedent's E (Specify only highest gi	ducation ade completed)		16a. Dece	dent's Usual	Occupati k done di	tion urina mosi	t of worki	na			usiness/Ind	•	_
21215-0036	within ane. then "	Completed	Elementary/Secondary (0-12)	College (1-4	4or 5+)		kind of work DO NOT use hief \					_		d Stat	es	
d 2	TO 100 to 100		17. Father's Name (First, Middle, Las		1_		iiici ,				(First, Middle	Ar , Maiden		ne)		_
/lan	should be and Mental marked c	To Be	Bruno Granito					-			aggin					
Maryland	2 2 2 2 3		19a. Informant's Name/Relationship Mary Oxenham - ni				-				Route Numb					
	of Health item 27 other tr		20a. Method of Disposition		20b. Pla		sition (Nam				ate2005			- City or Tov		
imo	Page nent c ant: If ury or		1 ☐ Burial 2 ☐ Cremation 3 [ '4 ☐ Donation 5 (XOther (Spec	JRemoval from Si //entombm	izie i					Apri]	21,	Bal	timo	ore, N	Maryland	
Baltimore,	pernit. Pages 'Department of H Importent: If ite any njury or of		21. Signature of Funeral Service Lice	insegun!	K)						bard F				Inc. and 21229	)
	Priysician	0 15	23a. Part 1. Enter the disease or cor shock, or heart failure. List only Immediate Cause (Final disease or condition	nplications that can y one cause on ear	used the death.	Po not ent	er the mode	of dying	such as	cardiac c	r respiratory a	rrest,			Approximate Interval Between Onset and Death	Ţ
3	/Medical Examiner		resulting in death)	Due to (o	r as a conseque	ence of):	· · · ·	Je a	4	Sa	lire			12	1975	
8760,	ite be executed sysician and ne burial-transit	Ical Examiner	Sequentially list conditions, 2, 4, each of the clustic cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (o	r as a conseque	ence of):							-			
.O. Box 68	death certifics e attending ph ed for use as t	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		th 2 ☐ Fetal on that time of dea	leath 3	Ectopic pre							ite of deliver	y Day Year	
S, D		by	Part II. Other significant conditions	contributing to dea	ath but not result	ting in the u	nderlying ca	iuse give	n in Part I.		23e. Did t		ise cont		a cause of death?	
Record	The law requires ate has been sign page 2 should be	Completed									24a. Was auto perfo 1 \( \text{Yes} \)			prior to con death?	sy findings availal pletion of cause o 2  No	ble of
Vital	Physicien: Th this certificate ral director, pag	Be (	25. Was case referred to medical examiner?	Literanitali				-		of Death	(Check only o	one)				
of	Physic this all dia	은	1 ☐ Yes ♠ No  27. Manner of Death	Hospital: 1 ☐ In 28a. Date of		R/Outpatier		April 1997	NU NU	-	ne 5 ☐ Resi 28d. Describe				)	
no	ing After une	tlon	1. Natural 5 ☐ Pending	(Month	, Day Year)	Injury	M Z	3c. Injury Work 1 □ Y	at ? ′es 2 □ l		and Describe	now injur	y occur	rea		
Division	of or Attending after death. Director: After d in by the fune	2 Naccident intestigation									per or Rural	Route Number,				
_	Hospite 24 hours Funerel tely filled	edical C	29a. Certifier (Check only one)  29a. Certifying P  Certifying P	hysician: To the base and manner	sis of examination	ledge, deati on and/or in	n occurred a vestigation,	at the time in my op	e, date an inion, dea	d place, a	and due to the ed at the time,	cause(s) date and	and ma I place,	anner as sta and due to	ited. the cause(s)	
	To the To the comple	Me	29b. Signature and title of certifier		7		29c.	License	number	_		29d. Dat	te signe	d (Month, £	Day, Year)	
)	Al /	2	• //	~ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	7		10	47	744	)		HDO	1:	20, 2	005	
1	JA		Hodren Cate	completed cause	1 Wa	(den	Print)	06	Lan	e (	Catons	Svill	l I	Mas	Jad.	
	Sta Registi		31. Date filed (Month PR 2 6	2005	gistrar's Signatu	k 1										

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registral Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** Year 12:00 PMM Doretta Jean Gibson April 24, 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Gilchrist Center for Hospice Care Towson Baltimore 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1□M 200 F Director 73 234-44-2401 04/03/1932 WV Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show the Madical Examiner must be notified at 1 Yes 2 No Director Randolph Elkins 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Route 3, box 124 26241 United States Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ö 1 ☐ Yes 2 No δ Specify: 3 Widowed 4 □ Divorced "natural". White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. I **other than** " Health Care Elementary/Secondary (0-12) College (1-4or 5+) Nursing Assistant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be is 1 and 2 should be fi of Heelth and Mental H Itam 27 is marked of Raymond Haller Wilma Murphy 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Debra K. Gibson /Daughter 9604G Amberleigh Lane Perry Hall, MD 21128 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Pages 1 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Apr 26 permit... Page Department of Important: If any injury or once. \*4 □ Donation 5 □ Other (Specify) Beltsville, Maryland Chesapeake Crematory Inc. 2005 21. Signature of Funeral Service Licensee 22. Name and Address of Facility M00986 Cremation and Funeral Alternatives - Hule 8717 Green Pastures Drive Baltimore, Maryland 21286 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) mentho /Medical Due to (or as a consequence of) Examiner Sequentiary list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) signed by the attending physiclen and does detached for use as the burial-trae resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Month Day 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ ★ 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? 1 Yes 2 🗆 No 1 Yes 2 No Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other} \) (Specify) 1 ☐ Yes 2 TNo Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Director: After 1 Natural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No the f 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide ö within 24 hours 6 To the Funeral L Hospitel that Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 25205 ces 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5 m 31. Date filed (Month, Year) 6 2005 32. Registrar's Signature State 6 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** April 22, 2005 Margaret M. Gerace 3:38 P /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Locetion of Death Examiner Towson
If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Greater Baltimore Medical Center Baltimore 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□M 2⊠F Director 220-24-6439 76 Oct. 1. 1928 Marvland Usual Residence of Decedent 10a. State 10c. City, Town or Location Show 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, ite Medical Examinational be matified at once. 1 ☐ Yes 2X No **Funeral Directo** Md. Baltimore Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 28 Allegheny Ave. Apt. 2601 21204 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify: þ 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Accountant State of Maryland 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Paul Deupert Catherine Meckes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 28 Allegheney Ave Apt. 2601 Towson Md. 21204 ace of Disposition (Name of Date 20c. Location - City or Town, State Mr. Anthony Gerace/Husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) Dulaney Valley Mem. Grd. 4/29/05 | Timonium. Maryland 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 21. Signature of Funeral Service License 1050 York Road Towson, Maryland 21204 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Preysician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause in that initiated events resulting in death) Last Due to (or as a consequence Examiner physician and the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical as IF FEMALE: use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 Other (specify) P.0. ed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۵ 2 🗆 No 3 Probably 4 Unknown Yes Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an s certificate has b autopsy performed? Division of Vital or Attending Physician: director. 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 25 1 Dipatrent 2 ER/Outpatient 3 DOA After this funeral 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Vatural 5 Pending Injury after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident the 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Hospital within 24 hours a To the Funeral Completely filled it Certifying Physicien: To he best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical d title of certifier 29b. Signatur 29d. Date signed (Month, Day, Year) Name and address of person who completed cause of death (Item 23a) (Type, Print) UBMDO 32. Registrate Signature 31. Date filed (Month, Day, Year) State APR 2 6 2005 Registrar

SCO, MONTORIPE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) Certificate of Death 2. Date of Death 3. Time of Death Month Physician 4:00 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Home 9. Birthplace (State or Foreign Country) 5. Social Security N 7. Age (In yrs. last birthday, **Funeral** Days Months 246-68-384 Usual Residence of Decedent TRINIDAL Yrs. Director 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or Items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 1 Yes 2 No **Funeral Director** MD 10e. Street and Number 10g. Citizen of What Country? 4101 . Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 TVNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 2 No þ Specify: 3 Widowed 4 Divorced "natural" Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any injury or other traumatic even" Elementary/Secondary (0-12) College (1-4or 5+) Th GRADE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 M Cremation 3 ☐ Removal from State Battimore \* 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Fability Waughn C Greene Funeral Services 21. Signature of Funeral Service Licensee Rd! Kandallstown Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** PROSTATE METASTATIC /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Certification: To Be Completed by Physician/Medical within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physi completely filled in by the funeral director, page 2 should be detached for use as the I IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 pronths?

1 Yes 2 No 9 Unknown 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? (es 2/A/No 2 🗆 No 1 ☐ Yes 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1. Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 T Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar

-19-05

YEDRY VIVIAN

State 31. Date filed (Month, Day, Year) istrar APR 2 6 2005

/ M.D. - ZZII W. ROGERS

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AVE-BALTIMORE MD

			For State Registrar	State of	Marylan		artment of H	lealth a			CUU3	14057
	Physicia	an	1. Decedent's Name (First, Middle	, Last) 2cman						Date of Death Month	Day / Year	3. Time of Death 400 AM
	/Medic Examin		4a. Facility Name (If not institution	give street and num	ber)		4b. City, Town, or	r Location of			4c. County of Dea	th
Ī	Funeral Director		5. Social Security Number 577–22–5337		. Age (In yrs. I	ast birthday) Yrs.	If Under 1 Year Months Days	If Under Hours		Date of Birth Month, Day, Y 11y 15		thplace (State or Foreign ountry)
	Maryland f show	tor	Usual Residence of Decedent  10a. State 10b. County Carro.	11		, Town or Lo						10d. Inside City Limits 1 X Yes 2 □ No
:	3e or 28e-	Funeral Director	10e. Street and Number 7309 Second Ave	enue			10f. Zip Code 21784			10g	. Citizen of What C	ountry?
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Department of Heath and Mental Hygiene.  Introprent: If tem 27 is marked other than "netural", or items 23e or 28e-f show any Injury or other treumetic event, I'm Medical Examination initial temporate of the any Injury or other treumetic event, I'm Medical Examination initial temporate of the any Injury or other treumetic event, I'm Medical Examination in the Injury or other treumetic event, I'm Medical Examination in the Injury or other treumetic event, I'm Medical Examination in the Injury or other treumetic event, I'm Medical Examination Injury or other treumetic events.	by	11. Marital Status  1 Never Married 2 Marri 3 Wildowed 4 Divorced	12. Was Deced Armed Ford 1 □ Yes 2 If Yes, Give Year or Dat	es? No		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☐ No	lispanic Ori an, Mexicar Specify:	n, Puerto Rica	Yes or No- an, etc.)	14. Race - Am Black, Whi	te, etc.
21215-0036	d within 72 ho giene. er than "netur , the Medical	Completed	15. Decedent (Specify only highes Elementary/Secondary (0-12)	's Education it grade completed)  College (1-	4or 5+)	(Give life.	dent's Usual Occup kind of work done o DO NOT use retired nemaker	ation during mos d)	t of working		b. Kind of Business	/Industry
nd	should be filed ind Mental Hygi i marked other umetic event, t	To Be (	17. Father's Name (First, Middle, Harold Fitzge)	cald				Rena	Cummi	ngs	iden Sumame)	
	l and 2 shi lealth and im 27 is m her treum	(8)	Deirdre Tarr (c		20h B	7663			., Uni	versity	Park, F	L 34201
Baltimore,	Pages 1 nent of H ent: If ite ury or ot		20a. Method of Disposition  1   Burial 2 □ Cremation  4 □ Donation 5 □ Other (S <sub>i</sub>		- C	emetery, cre	eld Cemet		Date -18 <b>-</b> 05		c. Location - City or rkesville	
Balt	permit. Departr Importe any Inj		21. Signature of Funeral Service  Pugu Djarg	4 .	<i>x</i> +		2. Name and Addres				al Home 8 21784	& Chapel
	Physician buly sician and buly sician and street per seconded to the private street and street stree	i Examiner	23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, reading to annual to any the disease or injury that initiated events resulting in death) Last	abue to (c	used the death ch line.  FROM as a consequence as a conse	nye uencyof): <u>flyre</u> uence of):	er the mode of dyin	g, such as	cardiac or re	spiratory arrest		Approximate Interval Between Onset and Death Weeks  Years
.O. Box 68760	ath certif attending for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown		th 2 Fetal int at time of de	Ideath 3	Ectopic pregnancy Other (specify)	,			23d. Date of de Month	livery Day Year
ecords, P	w requires that the de been signed by the should be detached	by	Part II. Other significant condition	ons contributing to dea	ath but not resi	ulting in the u	nderlying cause giv	en in Part I	.	23e. Did tobac	_	o the cause of death?
l Rec	The lavate has	Completed								24a. Was an autopsy performe	prior to	utopsy findings available completion of cause of
Vital	Physicien: Th this certificate ral director, pag	To Be (	25. Was case referred to medical examiner?  1 Yes 2 No	Hospital:	patient 2	ER/Outpatie	nt 3□ DOA Oth	or		heck only one)	ce 6 □Other (Spe	naife)
on of	ding Phy h. After this funeral c		27. Manner of Death  1 Natural 5 Pendin	g 28a. Date or (Month		28b. Time o	f 28c. Injur Wor	-	28d.		injury occurred	Cuyy
Division	al or Attending satter death. I Director: After d in by the fune	Certification:	2 Accident investig 3 Suicide 6 Could 4 Homicide determ	not be 28e. Place	of Injury - At ho g, etc. (Specify	ome, farm, st	reet, factory, office		-	Location (Stree City or Town, S	et and Number or R State)	ural Route Number,
	To the Hospitel or Attending R within 24 hours after death. To the Funerel Director: After completely filled in by the funer	Medical C	29a. Certifier (Check only one)  Check only 2 Medical	g Physician: To the Examiner: On the ba and mann	sis of examina	wledge, deat tion and/or in	h occurred at the tir vestigation, in my o	ne, date ar pinion, dea	nd place, and ath occurred a	due to the causet the time, date	se(s) and manner a a and place, and du	s stated. e to the cause(s)
	To the To the comp	Ň	29b. Signature and title of pertifie	1.10	no		29c. Licens		120		Date signed (Mon	
	Э		30. Name and address of person	who completed cause	of death (Item	1 23a) (Type,	Print) St 307	150	ctmin	ctor	MD 2	1157
	Sta Registr		31. Date filed (Month, Day, Year)	PR 2 6 200	gistrar's Signa	ture	y Speak	,	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	-10	MD 2	

DHMH 17 Rev 1/2001

DHMH 17 Rev 1/200

State Registrar 2 North

Avenue Bel Air Manylund

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Year 3.07 5W Houri E JESSE APRIL 202005 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner BALTIMORE JOHNS HOPKINS BAYVIEW 7. Age (In yrs. last birthday) | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day Yeer) | 0 2 / 0 1 / 1 9 4 1 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral ₩**M 2□F 212-40-1937 Director NORTH CAROLIN Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits rai', or items 23a or 28a-f ehow Examiner must be notilied at 1 ☐ Yes 2 No BALTIMORE MDMIDDLE RIVER Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21220 7A OAK GROVE DRIVE USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced WHITE "natural" er than "nature the Medical E Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12YRS College (1-4or 5+) US. GOVERNMENT POSTAL WORKER permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important; if Item 27 is marked oth any injury or othar traumatic event ODGs. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) JESSIE O. HOLLIE MYRTLE WOODALL 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) BONNIE M. HOLLIE(WIFE) 7A OAK GROVE DRIVE MIDDLE RIVER, MD 21220. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State `4 Donation 5 Dother (Specify) HOLLY HILL 04/23/2005 MIDDLE RIVER, MD. 21. Signature of Fureral Service Licensee 22. Name and Address of Facility relie HENRY W. JENKINS & SONS CO. 16924 YORK RD MONKTON, MD. Approximate Interval Between Onset and Death 23a, Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) HEMORRHAGE ihr Physician /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the aid be detached f ☐ Yes 2☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by toeric ANEURYSM Abdom: NAL 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No autopsy performed? 1 Yes 2 No To the Hospitei or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1XYes 2□ No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) After thi 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending 1 Yes 2 No М 2 Accident **Director:** 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours after To the Funeral Dire 1 🖸 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier RES-000 APRIL 20, 2005 RESIDENT 30. Name and andress of person who completed cause of death (Item 23a) (Type, Print) MARYLAND WOLFE STREET BALTIMORE 31. Date filed (Month, Dav. Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

APR 2 6 2005

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene amend item 323b PER PHY G842 4/29/Gertificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death **Physician** SAMPSON ROWLAND HELSEL April 23, 2005 5:10 pm /Medical 4a Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Knollwood Manor Millersville Anne Arundel Date of Birth (Month, Dey, Yeer) If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year Birthplace (State or Foreign Country) **Funeral** Days 1 X X 2 F 234-40-5621 77 Yrs Director West Virginia June 9, 1927 Usuel Residence of Decedent filed within 72 hours after death with the Marylend 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits terms 23a or 28a-f shored at must be notified at Director 1 ☐ Yes 2 ☐ No MD Howard Columbia 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 10213 Westwood Drive 21044 U.S.A. Funeral 12. Was Decedent Ever in U,S.
Armed Forces?
1 ⊠ Xes 2 □ No 1950 —
If Yes, Give
Yeer or Dates: 1952 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc XX Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1□Yes 2√√No Specify: Specify: 2 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry than Elementary/Secondary (0-12) College (1-4or 5+) Grade 12 Hairstylist/Barber Barbershop/Salon 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be and Mental H Pages 1 and 2 should be Jacob A. Helsel Biddie A. Kanode 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) item 27 i Juanita Helsel Chapman/sister 10213 Westwood Drive Columbia, MD other 1 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ₽ = ō 4 ☐ Donation 5 ☐ Other (Specify) MD Veterans Cemeterv 5/2/2005 Crownsville, MD 22. Name and Address of Fecility
Donaldson Funeral Home, P.A. 21. Signature of Funeral Service Licensee -/ M00770 313 Talbott Avenue Laurel, Maryland 20707 complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, only one cause on each line. 23a. Part1. Enter the disease, of shock, or heart failure. List Approximate Interval Between Onset and Death **Physician** /Medical Immediate Ceuse (Final disease or condition resulting in death) ACUTE RENAL FAILURE Examiner Physician/Medical Examiner 6 MONIHS BLADDER CANCER Attending Physician: The law requires that the deeth certificate be executed use es the buriel-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or as e consequence of) Due to (or as a consequence of) Part II. Other eignificant conditions contributing to deeth but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yee 2 ☐ No 3 ☐ Probably 4 ☐ Unknown þ page 2 should be Completed 24a. Wes an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of deeth? 2 No 1 ☐ Yes 2 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Piece of Death (Check only one) Hospital: ဥ Other: Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 DOA funaral 27. Manner of Deeth 28e. Date of Injury (Month, Dey Year) 28b. Time of Injury Medical Certification: 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 Pending investigation 1 Yes 2 No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, State) 4 Homicide ò

Division of Vital Records, P.O. Box 68760, I Director: A filled in by To the Hospital within 24 hours a To the Funeral C completely filled

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner as stated.
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. 29b. Signature end Rle of certifier 29c. License number D31136 9005 KICBRIDE

WALLACE MD
32 pagistrer's Gignature BRIAN C.
31. Dete filed (Month, Dey, Yeer)

State Registrar 29a. Certifier

APR 2 6 2005

D

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Month 4:05 AM John /Medical Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, PUG. 2), 9. Birthplace (State or Foreign Country)
. CUROUMA 6. Sex **Funeral** 12 M 2□ F 219-26-1065 Director 66 Yrs. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location if of Heelth and Mental Hygiene.
If item 27 is marked other than "natural", or items 23a or 28a-f show or other treumstic event, it a Mucical Examilian is used to mailing as 10d. Inside City Limits Baltimore 1 Yes 2 No **Funeral Director** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2308 21218 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Specify: Black Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Be Completed by 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) SUPERVISOR Jani torial Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be filt Department of Heelith and Mental Hy Importent: if Item 27 is marked oth any july or other treumatic event 2008: Jenio Highe ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4807 Guteway IERR BALTO MO 21237 ummie Tillery brother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State GURRSON FOREST V.A. \* 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 21229 23a. Part1. Enjer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) met ustutice Physician Adeceination /Medical Due to (or as a consequence of): Examiner Adenouncing Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed use as the burial-transit Accident CALEPUMI been signed by the attending physician and should be detached for use as the burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Medical Certification: To Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No
9 Unknown 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Pleava 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy performed? 2 7 No 2 No 1 Yes or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3□ DOA completely filled in by the funeral 27. Manner of Death 28b. Time of Injury 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Director: After Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funerel ( 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 25 IC 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JOVKEFF BALTLUCIE ST. 31. Date filed (Month, Day, Year) 32. Segistrar's Signature State APR 2 6 2005 Labor Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygierie Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** :30 PM 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ce octor ham ommunity T. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** Days Min. 1 M 2 € F Hours Months -1294 055-24 Director 1100 Usual Residence of Decedent 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits or Items 23a or 28a-f show other traumatic avant. It is Madical Examiner must be notified at 1 ☐ Yes 2 No Funeral Director Maryland rorrestvill Howel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? SA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 2 No 1 Never Married 2 Married Maryland 21215-0036 Black 1 ☐ Yes 2X No Specify: Be Completed by 3 ☑ Widowed 4 □ Divorced "natural" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within t of Health and Mental Hygiene. If Itam 27 is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Socia 12 Worker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be William Hale arric 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3702 Darlington - Niece Ave 20747 Demetra Melrose torrestville Maryland Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Surial 2 ☐ Cremation 3 ☐ Removal from State o permit. Page Department o Important: If any injury or once. Calverton National Cemetery 5/2 105 Callerton ' 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Chinn Funeral Service 2605 S. Shirlington Ed. Arlington, Va. 22206 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** CARDIORESPIR ATORY ARREST /Medical Due to (or as a consequence of) **Examiner** PNEUMONIA Esquestically list acroditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of): tha Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transit Due to (or as a consequence of) Box 68760, physician as IF FEMALE: for use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4 Pregnant at time of death 5 Other (specify) P.O. the detached 9□ Unknown 9 🗌 Uпклоwп Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ peq FAILURE 1 Yes 2 No 3 Probably 4 Onknown page 2 should Be Completed PERTENSION 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an rmed 2 No 1 Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: Cther: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 Inpatient Medical Certification: To 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Natural 5 Pending Injury within 24 hours after death.

To tha Funeral Diractor: A completely filled in by the fu 1 ☐ Yes 2 No 2 Accident investigation 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 🌠 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of gertifier 4/23/05 D0058290 Weller 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 SURESHKUMAR QUEENSBURY RD- HYATTSVILLE, MD 20181 MUTTATH 4203 31. Date filed (Month, Day, Year) 32. Registrar signature State APR 26 2005 Registrar

			1 - For State Registrar	State of M	arylan	•	artment rtificate	t of H	ealth a		ental Hy	Reg. No:	00	5	14063
	Physici /Medic	an al	1. Decedent's Name (First, Middle David Andrew Ho	lthaus			45 655	Fil	Lanting	of Death	2. Date of De Month APRI	L Day	Zi, Ž	ear 205	3. Time of Death
- 1 <sub>0</sub>	Examin	ر ا	4a. Facility Name (If not institution, Saint Jose)	oh Medical	Cer	ter	4b. City,		Location of	OWS	8. Date of Bir		В	alti	imore
	Funeral Director		5. Social Security Number 213-58-2702 Usual Residence of Decedent	6. Sex 7. As	5 4	last birthday) Yrs.	Months	Days	Hours	Min.	(Month, Da	y, Year)		Country	ce (State or Foreign y)
Maryland	-f show	tor	10a. State 10b. County	more City		y, Town or Lo		- 1						100	1. Inside City Limits 1 X Yes 2 □ No
with the	E or 28e	Direc	10e. Street and Number 3605 Belair Roa			- 12	10f. Zip						zen of Wh		
1215-0036 within 72 hours after death with the Maryland	Department of Health and Mental Hygiene. Importent: or Items 23s or 28e-1 show importent: If Item 27 is marked other then "naturel", or Items 23s or 28e-1 show any Injury or other treumatic event, Item Medical Examination unation and page.	by Funeral Director	11. Marital Status  1 Never Married 2 Marria 3 Widowed 4 Divorced	12. Was Decedent Armed Forces	?			lent of Hi	spanic Ori n, Mexican Specify:	i, Puerto I	cify Yes or No Rican, etc.)	-	14. Race -	Americar White, et	n Indian, c.
<b>21215-0036</b> od within 72 hours af	ne. Ihen "nature is Medical E	Completed	15. Decedent (Specify only highes Elementary/Secondary (0-12)	t's Education at grade completed)  College (1-4or	5+)	(Give	dent's Usua kind of wor DO NOT us Fitte	rk done d se retired,	ation luning most	t of workin	ng	16b. Ki	nd of Busi	ness/Indu	
Maryland 2	Mental Hygie irked other i ific event,	To Be Co	17. Father's Name (First, Middle, Herman Joseph H	ŕ		TIPC	11000				(First, Middle,				
, Mary	alth and A n 27 is ma er treuma		19a. Informant's Name/Relationsl				7				ingham,	-			code)
Baltimore,	ment of He ent: If Iter ury or oth		20a. Method of Disposition  1 Burial 2 Cremation  4 Donation 5 Other (Si	3 □Removal from State pecity)	,   0	Place of Dispo cemetery, crei esapea	matory or o	ther place	-	A	pr 22 2005		cation - Ci		n, State aryland
Ball	Depart Import any In		21. Signature of Funeral Service.	Licensee Licensee	1009	84 C		ion a	nd Fu	ineral	l Alteri Drive			Mary	yland 2128£
3760, <	Medical xaminer transit the private transit tr	dical Examiner	23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. HEPAT  Due to (or as	IC E s a conseq TAGE s a conseq	ENCEPH uence of): ELIVE	HALOP	АТН	Υ	Cardia's o	Tophatory a	11031,		li li	Approximate Interval Between Onset and Death
O. Box 68	y the attending ched for use as	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Feta	I death 3	⊒Ectopic pro ☐ Other (sp						23d. Date Month		/ Vay Year
	n signed by	by	Part II. Other significant condition			ulting in the u	inderlying c	ause give	en in Part I		23e. Did t	_	/		cause of death?
I Records,	ate ha	Completed	ANEMIA				_				24a. Was auto perfo	an psy ormed? 2 No	pri	or to comp ath?	sy findings available pletion of cause of No
of Vital	is certifical director, p	Be	25. Was case referred to medical examiner?	I Managhali N. F.				Othe			(Check only				
O A	After	ation: To	1 Alipatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Hesidenc												
-		Certification:	3 ☐ Suicide 6 ☐ Could of determine		ijury - At h tc. (Specil	ome, farm, st	reet, factory	, office			28f. Location ( City or To			or Rural I	Route Number,
T Jetinson e		edical	29a. Certifier (Check only one) Certifyin 2 Medical	ng Physicien: To the besi Examiner: On the basis of and manner s	of examina	owledge, deat ation and/or in	th occurred evestigation,	at the tim , in my op	ne, date an pinion, dea	nd place, a th occurre	and due to the ed at the time,	cause(s) date and	and manr place, an	ner as stat d due to t	ted. he cause(s)
To the	within 2 To the	Me	29b. Signature and title of certifie	Va			290	. License	number				e signed (	4	
•	- 2		30 Name and address of account	o completed assess of	doath /ltc-	n 23a) /Tun-	Print)	D 3	7254			4	120	107	
	5		30. Name and address of person  BOON P. LIM.	Id Y's "77.7"	271 4 C	OF ED	TN D T H	ET	OWSO	N. h	10RYL 0	ND :	2120	4	
	Sta Registi		31. Date filed (Month, Day, Year)	6 2005 32. Regist	trar's Signa	ature	Carl !	9		7					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 16064 Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** McDonald K. Hamilton Month 18 2005 April 10:55 Ma /Medical 4a. Fecility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death Baltimore 4c. County of Death Univ. Of Maryland Medical Syst 5. Social Security Number 8. Date of Birth (Month, Day, Yeer) Feb. 21, 1930 6. Sex If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral**  Birthplace (State or Foreign Country) Days 15 M 2 □ F 75 Director 377-26-9467 MI Usual Residence of Decedent the Maryland 10a, State 10b. County 10c. City, Town or Location or 28a-f show 10d. Inside City Limits rai', or itams 23a or 28a-f shor Examiner must be mulfied at MD Anne Arundel Director Severna Park 1 ☐ Yes 2 → No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 62 Brandywine Avenue 21146 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠ Yes 2 □ No 196 If Yes, Give Year or Dates: 196 11 Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1960-1 ☐ Yes 2 ☒ No ρ Specify: Specify: White 3 Widowed 4 Divorced "natural" 1962 Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

Chairman, 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry University of MD Il Hygiene. other than Elementary/Secondary (0-12) College (1-4or 5+) 5+ Oral & Maxillofacial Surgery School of Denistry 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should ba nent of Health and Mental Roy Hamilton ဥ Frances J. Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) f Health item 27 I other tra Mary H. Hamilton/Wife 62 Brandywine Avenue, Severna Park, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Burial 2 □ Cremation 3 □ Removal from State r. 22, 2005 permit. Page Dapartment of Important: If any Injury or once. Apr. MD Veterans Cemetery ' 4 ☐ Donation 5 ☐ Other (Specify) Crownsville, MD 21 Signature of Funeral Service Licenses Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy, Severna Park, MD 25a. Pan 1. Enter the disease, or confolications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Cardiac Arrest /Medical Due to (or as a consequence of) Examiner Stroke Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): attending physician and for use as the burial-transit certificate be axacuted Myocardial Infarction resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy 4 Pregnant at time of death Month Day Year ed by the a detached f 5 Other (specify) P.O. 9 Unknown 9 Unknown bean signed by t should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, à Cancer -Throat Completed 1 Yes 2 No 3 Probably 4X⊡Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 X No : After this certifica a funeral diractor, p Hospitel or Attending Physicien: Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 2 ER/Outpatient 3 □ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Yeer) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred X Natural 5 Pending investigation hours after death. I Director: A ad in by tha ft 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours a To the Funerel I Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical 29b. Signatury and title of 29c. License number 29d. Date signed (Month, Day, Year) D75223 April 20, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Fermin Barrueto Jr. MD, 22 S. Gre MD, Greene St.Baltimore, Md 21201 31. Date filed (Month, Day, Year) 🔑. Registrar's Signature State Registrar APR 2 6 2005

DHMH 17 Rev 1/2001

amend item#250, perME, 6844, 6730/05 Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene For State RegistrAMEND ITEM #28a-f PER ME C842 CETHIFFE OF Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Edward William Hudson /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Mary land Clinton southern Hos 6 evree Dital If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (Ih yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1**∑**M 2□F 217-36-8401 Yrs. Director 73 Nov. 8,1931 PA Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other treumetic event, the Musical Everithms. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ▼ No Directo Maryland Prince George's 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 8602 Lantern Lane 20735 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1040 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1√Pes 2 No 1949-lt¥es, Give Year or Dates: 1951 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No White Specify: 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Mechanic Oil Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mary Crocker Evan Hudson 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Inger B. Hudson (Wife) 8602 Lantern Lane Clinton, Maryland 20735 20a. Method of Disposition 20b. Place of Disposition (Name of Aprile 20, 20c. Location - City or Town, State cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 2005 \* 4 ☐ Donation 5 ☐ Other (Specify) Maryland Veterans Cem. Cheltenham, Maryland 21. Signature of Fun ry Service Lens 22. Name and Address of Facility Lee Funeral Home, inc. 6633 Old Alexandria FerryRoad Clinton, MD 20735 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Asphysication

Due to (of as a consequence of): Physician due to disease or condition resulting in death) /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of). Examiner Attending Physician: The law requires that the death certificate be executed that initiated events been signed by the attending physician and should be detached for use as the burial-tran resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? certificate 1 ☐ Yes 2 ☐ No 1 Yes 22 No director Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of : 09 28d. Describe how injury occurred After 1 Natural 5 Pending death. investigation 1 ☐ Yes 2 → No APR 14,2005 s after death 2 Accident <del>UNK</del> SUBJECT HANGED SELF the 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 8602 LANTERN LANE CLINTON, MD. within 24 hours a To the Funerei I AT HOME 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) April 16, 2005 30. Name and address of person who concleted cause of death (Irim 23a) (Type, Print) HOSPI 2005 Registar's Signature

DHMH 17 Rev 1/2001

State Registrar

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 15 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Month **Physician** Year 22, 2005 0705 April Viola I. Hayase /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** 8. Date of Birth (Month, Day, Year) Montgomery Suburban Hospital Bethesda If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 ☐ M 2 🛛 F Director 86 Yrs 1919 Idaho 025-26-0169 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ?7 is marked other then "naturel", or items 23a or 28e-f show treumetic event, the Medical Examinat must be notified at 1 ☐ Yes 2X No Directo Maryland Montgomery Bethesda 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9903 Carnegie Terrace 20817 United States Funerai filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 전 No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Completed by Specify: 3 ☐ Widowed 4 ☐ Divorced Asian 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Massachusetts Institute al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) of Technology Technical Assistant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be fill ment of Health and Mental Hitem 27 is marked of Be Joseph Ishiguri Chiyoko 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9903 Carnegie Terrace, Bethesda, Maryland Joshua Y. Hayase/Husband 20817 20b. Place of Disposition (Name of cemetery, crematory or other place)
Montgomery April 25, 20c. Location - City or Town, State 20a Method of Disposition 1 ☐ Burial 2X Cremation 3 ☐ Removal from State prium. Inc. 2005 Bethesda, Maryland
22. Name and Address of Facility Robert A. Pumphrey Funeral Home/
Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue
Bethesda, Maryland 20814-3501 Department or importent: if any injury or once. \* 4 ☐ Donation 5 ☐ Other (Specify) Crematorium, Inc. 21. Signature of Funeral Service Lice M00803 Bethesda, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Ventricular Fibrillation disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Cardiomyopathy Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transit Valvular Heart Disease that initiated events resulting in death) Last Due to (or as a consequence of): 68760, Physician/Medical Box IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

Records, Division of Vital

05

AYASE, VIOLA

Hospitel or Attending Physicien: funeral director, death. within 24 hours after deatl To the Funerel Director: filled in by completely

State

Registrar

31. Date filed (Month, Day, Year)

Certification: To

Medical

25. Was case referred to medical

2**X** No

5 Pending

investigation

6 Could not be determined

1 Tes

27. Manner of Death

1 X Natural

2 Accident

4 Homicide

(Check only one)

3 Suicide

29a. Certifier

29b. Signature and title of certifier

28a. Date of Injury (Month, Day Year)

1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) any manner stated. 29c. License numbe

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

D38888 April 22, 2005

26. Place of Death (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6410 Rockledge Drive, #200, Bethesda, Maryland Harry Bigham, M.D.

APR 2 6 2005

32. Registrar Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrat Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day April 23, 2005 6:50A Kathryn Taylor Hayes /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Sandy Spring

If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. Montgomery Friends Nursing Home 8. Date of Birth (Month, Day, June 30, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** 1□M 2XF 1913 Director Pennsylvania 91 200-07-7511 Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hyglene. Sem 27 is marked other than "natural", or Itams 23a or 28a-f show 10c. City, Town or Location r than "natural", or Itams 23a or 28a-f show the Medical Evantiner must be notified at 10b. County 10d. Inside City Limits 1 ☐ Yes 2X No Completed by Funeral Director Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20906 3208 Gleneagles Drive United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: 3 X Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be ° Bertha Bennett James Taylor 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6711 Mink Hollow Road, Highland, Maryland Margaret Blair Hayes/Daughter Itam 27 other t 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition April 26, permit. Pages 1
Department of H
Important: If Ita
any Injury or ot 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Montgomery orium, Inc. 2005 Bethesda, Maryland

22. Name and Address of Facility Robert A. Pumphrey Funeral Home/
Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue
Bethesda, Maryland 20814-3501 4 ☐ Donation 5 ☐ Other (Specify) Crematorium, Inc. 21. Signature al Service Licen M00803 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician Congestive Heart Failure /Medical Due to (or as a consequence of): Examiner Pneumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Be Completed by Physician/Medical Examiner The law requires that the death certificate be executed Due to (or as a consequence of): physicien ar s the burial-t Division of Vital Records, P.O. Box 68760. as t IF FEMALE: esn 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 ☒ No atten for u 3 DEctopic pregnancy Year 5 Other (specify) signed by the a d be detached for 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? res 2X No 1 Yes Hospital or Attanding Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only опе) Hospital: Other: 4X Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔀 No Certification; To 1 🗌 Inpatient 2 ER/Outpatient 3 DOA funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 XNaturai 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident Director: Could not be 3 🗌 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funaral L Medical 29a. Certifier 1 🖄 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D39793 April 25, 2005 recept W.D. , M.D. 18111 Prince Philip Drive, #207, Olney, Maryland 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 Christopher J. Mays, M.D. State Registrar

			For Stete	State of Mai	•	•	ment of F		Mental Hy	6	000	14068
	•	*:	Registrar  1. Decedent's Name (First, Middle, La	st)		00111	Toale of	Death	2. Date of D	Reg. No.		3. Time of Death
	Physici /Medic		LLoyd	Rice		Hi	ndman	Jr.	April	24	2005	9:30 am
	Examin		4a. Facility Name (If not institution, giv	street and number)		4	b. City, Town, o	Location of Deat		4c.	County of Dea	
			Franklin Square	Hospital				edale	1		Baltin	nore
	Funeral Director		5. Social Security Number 1 6. S 215–14–8066	ex 7. Age	(In yrs. last birth 81 Y		f Under 1 Year Ionths Days	If Under 24 Hrs Hours Min.	(Month, D	ay, Year)	9. Bii	thplace (State or Foreign ountry)
			Usual Residence of Decedent	Λ.	01				Nov. 1	7 19:	23	Maryland
	inyland show	_	10a. State 10b. County		10c. City, Town	or Locat	ion					10d. Inside City Limits
	he Ma 8a-f s	Director	Maryland Balti	more	Rose				*****			1 Yes 2 No
	a or 2	Dire	10e. Street and Number	A			10f. Zip Code	,		10g. Citi	zen of What C	ountry?
	72 hours after death with the Maryland natural', or items 23a or 28a-f show Jisal Examiner must be mulffed at	Funeral	1315 Chesaco	Ave. Apart			21237 s Decedent of H	ispanic Origin? (S	Specify Yes or N	0-	U.S.A.	erican Indian.
9	after or iter	Fun	1 Never Married 2 Married	Armed Forces?		If Y	es, specify Cuba	ın, Mexican, Puer	to Rican, etc.)		Black, Whi	te, etc.
03	ural', c	d by	3,☐ Widowed 4 ☑ Divorced	If Yes, Give Year or Dates:	1941	1 -	Yes 2 No	Specify:			Specify:	White
5-	"natu	Completed	15. Decedent's E (Specify only highest gra			Give kin	t's Usual Occup d of work done o NOT use retired	during most of wo	rking	16b. Ki	nd of Business	/Industry
12	within lene. than "	duic	Elementary/Secondary (0-12)	College (1-4or 5+)			enance W			Mai	rvland	State Gov.
d 2	be filed within 72 hours after death with the Marylan hat Hygiene of othar than Inatural', or liems 23a or 28a-f show event, the Mccical Examination and be millied at	a)	17. Father's Name (First, Middle, Last,		II.d	LILL	Harree V		me (First, Middle			beace dov.
/lar	should be ind Mental marked o	To B	LLoyd	Rice	Hindm	an S	Sr.	Cather	rine		Unkno	wn
Maryland 21215-0036	sum s		19a. Informant's Name/Relationship (	Type, Print)	19b.	Mailing A	Address (Street	and Number or Re	ural Route Numb	er, City o	r Town, State,	Zip Code)
	1 and 2 Health Ism 27 I		Reid Guanti ( 20a. Method of Disposition	Grandson )	914 20b. Place of I	Sou	th Wick	Drive T	lowson,	Mary!	Land 21	286
nor	ages nt of h t: If its		1 ☐ Burial 2√☐ Cremation 3 ☐	Removal from State	cemetery	, cremat	ory or other place	Thi	il 26,			
Baltimore,	permit. Pages 1 an Department of Heal Important: If itam 2 any injury or other		<ul><li>4 □ Donation 5 □ Other (Specif</li><li>21. Signature of Funeral Service Licental</li></ul>		Bayview		ematory	Inc. 20 SkiyChoj	005			, Maryland
ä	Depa Depa Impo any ir		Mash C	Chorna	The			-				nd 21224
	e		23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the	ne death. Do no							Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	CHF								Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a	consequence o	f):						
l.		er	Sequentially list conditions, if any, leading to immediate	b	consequence of	f):						
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events									
oʻ	an an arrial-tr	Еха	resulting in death) Last	Due to (or as a	consequence of	f):						
58760,	tificate be executed ig physician and as the burial-transit	edical		d		_						
_	sertific ding p		IF FEMALE:	23c. If yes, outcome of	pregnancy							
Вох	death certif e attending od for use a	clan	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2	Fetal death		topic pregnancy			2	23d. Date of de Month	livery Day Year
P.0.	that the death cented by the attendinded by the attendindet detached for use	Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□Unknown								
	S C 0		Part II. Other significant conditions of		not resulting in	the unde	rlying cause give	en in Part I.				o the cause of death?
ord	w require been sig should t	ted	Kenal tailure					<del></del>	10	Yes 2	⊒n√o 3 □ P	robably 4 Unknown
Sec.	has by	Completed by							24a. Was	psy	prior to	utopsy findings available completion of cause of
Vital Records,	The ate		25.14						1 ☐ Yes		death? 1 ☐ Yes	2 □ No
	Physician: this certific ral director,	o Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☑ No	Hospital:	2 ER/Outs	aationt	3C DOA Othi		ath <i>(Check only</i> Iome 5 ☐ Res			init al
of	g Physier this neral dii	n: To	27. Manner of Death	28a. Date of Injury (Month, Day)	28b. Ti	me of	28c. Injun		28d. Describe			City)
jor	Attanding Pir death. ector: After tiby the funera	atio	1 Natural 5 Pending 2 Accident investigation	1	111	ury		Yes 2 □ No				
Division	i or Attano after deatl Director: I in by the	Certification:	3 Suicide 6 Could not b 4 Homicide determined	28e. Place of Injury building, etc.	r - At home, fari (Specify)	n, street	, factory, office		28f. Location ( City or To	Street and wn, State)	d Number or R	ural Route Number,
	pital o		29a. Certifier 1 (Certifying Ph	veicing. To the heat of	and the students	donth or	and the state of the			( )		
	To the Hospital or Attanding lightin 24 hours after death. To the Funaral Director: After completely filled in by the funer	edical	(Check only one) 2 Medical Exer	ysician: To the best of niner: On the basis of e and manner state	xamination and	or inves	tigation, in my o	ne, date and place pinion, death occu	rred at the time,	date and	and manner as place, and due	s stated. to the cause(s)
	To the l within 2 To the complet	Me	29b. Signature and title of certifier				29c. License	number		29d. Date	a signed (Mont	h, Day, Year)
)			I win Whelen	1 mi	>		10006	0560		APR	12 24.	2005
	5		30. Name and address of person PANKAI 141 ETE	mpleted cause of dea	th (Item 23a) (T	ype, Pri			. P.	01.	14000:5	
	Sta	te ·	31. Date filed (Month, Day, Year)	34. Registrar	s Signature	8	1718	R WEC	10 F-3.	VSHV1	(mice	12
1	Registr	ar	APR 2 6 200	5 Silver	J. 13	304						

Hindman, Lloyd

		1	State of Maryland / Department of Health and Mental Hygiene  State Registrar  Certificate of Death Reg. No. 0 0 5   4 0 6 9
	Physici /Medic	าก	1. Decedent's Name (First, Middle, Last)  2. Date of Death  Month  Day  Year  April 25 2005 12 M
	Examin		la. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death  4c. County of Death
	Funeral Director		The specific of Decedent 111(3) For the specific of Decedent 111(3
	Marylend		10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits  NA. Palhimore 12 No
	th with the 23a or 28a ist be not	Funeral Director	10e. Street and Number  10f. Zip Code  10g. Citizen of What Country?  21215  4.5. A.
5-0036	72 hours efter death with the Marylend Instural, or Items 23a or 28a-f show Jisal Examinatioust be motified at	þ	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 3 Widowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces? 1 Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Specify: Specify:
21215-0	within ane. then *	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)
Maryland 2	ould be filed Mental Hygid varked other natic event, Il	To Be C	17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Maiden Sumame)  Katherine Taylor
	and 2 sho lealth and m 27 is mu		19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Boute Number, Cfty or Town, State, Zip Code)  Mildred Jessup wife 3802 Do field An Butter and Number of Rural Boute Number, Cfty or Town, State, Zip Code)
Baltimore	Pages 1 ment of Hi ent: If iter ury or oth		20b. Place of Disposition  1 Burial 2 Cremation 3 Removal from State  20b. Place of Disposition (Name of cemetery, crematory or other place)  4 Donation 5 Other (Specify)  20c. Location - City or Town, State  Carrison Forck U.A.Com  May 3, 2005  20c. Location - City or Town, State
Balt	permit. Pag Department Importent: any injury o		21. Signature of Funeral Service Licensee 22. Name and Address of Pacifity dans Funeral Service P.A.  22. Name and Address of Pacifity dans Funeral Service P.A.  1701 McCalloh St. Balto. Wd. 21217
	Physician		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a
	/Medical Examiner	L	Due to (or as a consequence off:  Sequentially list conditions  b.
Ī	xecutad and il-transit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):  Due to (or as a consequence of):  C. Due to (or as a consequence of):
68760	eath certificate be executad attending physician and for use as the burial-transit	dlcal	d
P.O. Box (	0 0	Completed by Physician/Me	FFEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown   No 2   Unknown   23c. If yes, outcome of pregnancy 1   Live birth 2   Fetal death 4   Pregnant at time of death 5   Other (specify)   23d. Date of delivery   Month Day Year   Yea
	requires that the een signad by th hould be detacha	d by Pr	Part II. Qther significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death?  1   Yes 2   No 3   Probably 4   Unknown
Division of Vital Records,	The law ate has b page 2 sl	Complete	24a. Was an autopsy findings available prior to completion of cause of death?  1 Yes 2 No 1 Yes 2 No
of Vita	Physiclan: Th r this certificate ral director, pag	To Be	25. Was case referred to medical examiner?  1  Yes 2 No
sion c	Ilng After fune	Certification;	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? M 1 Yes 2 No
Divi	ital or Att urs after d ral Direct lled in by	Certif	4 Homicide determined determined building, etc. (Specify)
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical	29a. Certifier (Check only one)  29b. Signafule and title of certifies  1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29c. License number  29d. Date signed (Month, Dey, Year)
	or with		1 25 D0054911 04-25-2005
5	' '	77	30. Name and address of person more completed cause of death (Nem 23a) (Type, Print) W. BEVELENE AVE., BAH MONE MD 21215  31. Date filed (Month, Day, Year)  32. Registrar's Signature
••	Sta Regist		APR 2 6 2005 April 15 April 2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Rag. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Month Year **Physician** 1:28 P.M APRIL 2005 Ronald S. Jester 20 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMBRE BALTIMORE CITY HOSPITAL N/A If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. Dec. 13, 7. Age (In yrs. last birthday) 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** 1946 1 XM 2□ F 58 Director 216-52-9347 Maryland Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits itam 27 is markad other than "natural", or itams 23a or 28a-1 show other traumatic event, the Modical Expedients and be notified at 1 ☐ Yes 2 ▼No Director Maryland Baltimore Randallstown 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 8414 Downey Dale Drive 21133 USA Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 X Yes 2 No 1965
If Yes, Give
Year or Dates: 1971 72 hours after 1 ☐ Never Married 2X Married 1 ☐ Yes 2 No Specify: Specify: White ò 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry d 2 should be filed within 7 th and Mental Hygiene. 7 Is marked other than "r Baltimore, Maryland 2121 College (1-4or 5+) 12 Electronics Technician Electronics 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Theresa Plantholt Willis Jester 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) is 1 and 2 s of Health an itam 27 ls Kathleen Jester, Wife 8414 Downey Dale Drive Randallstown, MD 21133 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If its
any injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc. | 04/25/05 Baltimore, Maryland 21. Signature of Funeral Service Licensee
Thomas Gregor <sup>22</sup> Name and Address of Facility
MacNabb Funeral Home, P.A.
299 Frederick Road Baltimore, Maryland 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) KLEBSIELLA **Physician** SEVERE /Medical Due to (or as a consequence of): **Examiner** NEUTROPENIA CHEMOTHERAPY FROM Eagle Mally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine burial-transit ADENOCARCINOMA METASTATIC Due to (or as a consequence of) physician Box 68760 Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 Other (specify) P.O. the 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. þ 1 2 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy 1 ☐ Yes 2 ☐ No 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 \sum Nursing Home 1 ☐ Yes 2 ☐ No 1 Impatient 2 2 ER/Outpatient 3 DOA 5 ☐ Residence 6 ☐ Other (Specify) this 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death After or Attanding 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No after death. 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 - Homicide Hospital 24 hours a 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical

State

0 2

tha the

S

12

Ś

KONALD

KNOW

TIENT

Registrar DHMH 17 Rev 1/2001 29b. Signature and title of certifier

NEELIMA

31. Date filed (Month, Day, Year)

agord

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6

ATRACADDA

32 Registrar's Signature

 $M \cdot D$ 

29c. License number

000

HOSPITAL

29d. Date signed (Month, Day, Year)

APRIL 20, 2005

BALTIMORF

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 15

			For State Registrar	State of Marylan		rtment of F Fificate of		Mental Hygie		140/1
	Physici	an	Decedent's Name (First, Middle, Last)					2. Date of Death Month	Day Year	3. Time of Death
	/Media	cal		rie Jones	,	4h City Town	al analisa of Dank	Apr	4c. County of Dea	
	Examir	ner	4a. Facility Name (If not institution, give:	lth of Be	Air	Bei /	Location of Deat		11 /	ord
	Funeral		5. Social Security Number 6. Sec	7. Age (In yrs.	ast birthday)	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	8. Date of Birth (Month, Day, Y	9. Bi	rthplace (State or Foreign country)
	Director		248-15-5910 Usual Residence of Decedent	м <b>жж</b> 99	Yrs.				.905 Ten	neśsee
	yland now		10a. State 10b. County	10c. City	, Town or Loca	ation				10d. Inside City Limits
	Ba-fsh	Director	Maryland Harford	В	el Air					1 ☐ Yes Ž No
	with th	Dire	10e. Street and Number 410 E. MacPhail	Road		10f. Zip Code	014	10g	Citizen of What C. USA	-
	ms 23	Funeral	11. Marital Status	12. Was Decedent Ever in U.	S. 13. W			pecify Yes or No- o Rican, etc.)	14. Race - Am	
Maryland 21215-0036	be filed within 72 hours after death with the Maryland stal Hyglene.  dd other than "natural", or Items 23e or 28e-f show event. The Mydical Exter it after mast be inclified at	by	1 ☐ Never Married 2 ☐ Married  3 ☑ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:		Yes, specify Cuba ☐ Yes 2 <mark>亿</mark> No	n, Mexican, Puer Specify:	o Rican, etc.)	Specify: W	hite hite
5-0	"natu	etec	15. Decedent's Edu (Specify only highest grad	cation e completed)	16a. Decede (Give ki	int's Usual Occup ind of work done O NOT use retired	ation during most of wo	rking 16	b. Kind of Business	s/Industry
121	filed withir Hygiene. other than ent, the M	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		ive Room	a)		Textiles	
nd	be filed tal Hygie d other event.	BeC	17. Father's Name (First, Middle, Last)				18. Mother's Nar	ne (First, Middle, Ma.	iden Sumame)	
yla	2 should be filed withir and Mental Hygiene. Is markad other than aumatic event, the M	To	Unknown					Unknown		
Mai	s 1 and 2 should f Health and Mer item 27 Is marks othar traumatic	1	19a. Informant's Name/Relationship (Ty Thomas Messer / G	* * *	W	10.00		ıra <i>l Rou</i> te Number, C 1. Bel <u>Air</u>		
re,	of Health item 27 other tr		20a. Method of Disposition	20b. P	lace of Disposi				c. Location - City or	
imo	nit. Pages eartment of I ortant: If it injury or o		1   Burial 2 □ Cremation 3   Other (Specify)	Grae		Cem. Wes	· !	2-05 Gr	eenville,	SC
Baltimore,	permit. Pages 1 ar Department of Hea Important: If item any injury or othal		21. Sign tup of Fund al Service License	mes)	Мс 13	Comasfur 17 Cokes	ieral <sup>lity</sup> Hor sbury Roa			
L			23a. Part1. Enter the disease, or compl. shock, or heart failure. List only or		n. Do not enter	the mode of dyin	g, such as cardia	or respiratory arrest		Approximate Interval Between Onset and Death
	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)	Urose	psis					1 week
	Examiner		f.	Due to (or as a consequ	Jence ot):					
7	p #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Classes or her) that initiated events	Due to (or as a consequ	uence of):					
V	xecute and II-trans	Examiner	that initiated events resulting in death) Last	Due to (or as a consequ	uence of):					
68760,	tificate be executed g physician and as the burial-transit	edicai E		1	,					
89	ntificat ng phy s as th		IF FEMALE:							2,00
Вох	eath certif attending for use a	Physician/N	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Fetal	death 3 □E	Ectopic pregnancy			23d. Date of de Month	olivery Day Year
P.O.	that the de led by the a detached	nysic	1 ☐ Yes 2 No 9 ☐ Unknown	4☐Pregnant at time of de 9☐Unknown	atn 5 □ t	Other (specify)				
S,	res that signed b		Part II. Other significant conditions cor				en in Part I.	23e. Did tobac	co use contribute t	o the cause of death?
ord	w require been sig	ted	Alzheim	er's Di	m(n)	c ·		1 🗆 Yes	2 No 3 □ P	robably 4 Unknown
Vital Records,	hasb pe2st	Completed by						24a. Was an autopsy performed	prior to	utopsy findings available completion of cause of
tal	sician: The certificate hir	e Co	25. Was case referred to medical				26 Place of De-	1 ☐ Yes 2	No 1 ☐ Ye	s 2 No
of Vi	Physicia this cert al direct	ToB	ayaminar?	lospital: 1   Inpatient 2	ER/Outpatient	3□ DOA Oth	or.	lome 5 Residence	e 6 Other (Spe	ecify)
o u	ding Pt I. After th funeral		27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injur Wor	k?	28d. Describe how	injury occurred	
Division	uttendi death. ctor: A y the fu	ficat	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - At ho	me farm stree		Yes 2 No	281. Location (Stree	at and Number or B	Tural Route Number
Δi	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filed in by the funeral director, page 2 should be deteched for use as the burial-transit	Certification;	4 Homicide determined	building, etc. (Specify	') 			City or Town, S	State)	
	Hosp 24 hos Fune etely fil	edicai	29a. Certifier 1 Certifying Physical (Check only one) 2 Medical Examination	sicien: To the best of my kno- ner: On the basis of examinal and manner stated.	wledge, death o tion and/or inve	occurred at the tinestigation, in my o	ne, date and place pinion, death occu	, and due to the caus rred at the time, date	e(s) and manner a and place, and du	s stated. e to the cause(s)
	To th within To th compl	Me	29b. Signature and title of certifier	-A.D.		29c. Licens			Date signed (Mon	
)			) NO	עוויי		D	34625	- A,	on, 1 20,	2005
	6		30. Name and address of person who co	mpleted cause of death (Item	23a) (Type, P.	rint)	R.	10-	Main la	2005 nd 21014
	Sta	ate	31. Date filed (Month, Day, Year)	3. Registrar's Signa	ture Asses	the s	7 T N1	1 13117 /	July In	
	Registr	_	APR 2 6 200	1 Planes B						

Amend Item 20a, c per in Black Indelible Ink. Ensure All Copies Are Legible.

For Amend Item 3 State of Maryland (Department of Health and Mental Hygiene )

		For Amend Item 3 per Dr., G842,047261 Registrar Cer	tificate of Death		2005 14072							
Physic /Medi		1. Decedent's Name (First, Middle, Last) Franklin Louis Kenney		2. Date of Death Month April 6,	Day Year 2005 Year 2:40 a.M							
Exami		4a. Facility Name (If not institution, give street and number) Southern Maryland Hospital	4b. City, Town, or Location of Death Clinton		4c. County of Death Prince George's							
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 76 Yrs.	If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, Ye March 4,								
and		Usual Residence of Decedent           10a. State         10b. County         10c. City, Town or Lo	cation		10d, Inside City Limits							
Mary P-f sho	tor	Maryland Prince George's Upper Ma	arlboro		1 □ Yes 2 □ No							
ath with the Marylar 23e or 28e-f show ust be notified at	al Director	10e. Street and Number 9910 Williamsburg Drive	10f. Zip Code 20772	10g. Citizen of What Country? United States								
after dez	by Funeral	1 Never Married 2 V Warried 1 Yes 2 No	Nas Decedent of Hispanic Origin? (Sp f Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☐ No Specify:	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White							
72 hours	Completed	15. Decedent's Education (Specify only highest grade completed) (Give	lent's Usual Occupation kind of work done during most of work DO NOT use retired)	ing 16t	b. Kind of Business/Industry							
e filed within al Hygiene. I other then 'vent, Ire Me	ldmo	College (1-4or 5+)	oonotuse retired) er/ Salesman									
ges 1 and 2 should be filed within to Health and Mental Hygiene. If item 27 is marked other then or other treumetic event, Ire Mental Health and Mental Ire Mental Health and Mental Ire Mental Health and Mental	Be Co	17. Father's Name (First, Middle, Last)		e (First, Middle, Mai	Anheiser Bush den Sumame)							
Menta Menta arked atic ev	To B	Frank Kenney	Viol	a May Bent	ton							
2 sho and is ma		D + + T/ (TT+ C )	g Address (Street and Number or Run									
1 and 1 and Health 8m 27 ther t		Betty Kenney (Wife)  9910 Williamsburg Drive, Upper Marlbord MD 20  20a. Method of Disposition  20b. Place of Disposition (Name of cemetary, crematory or other place)  April 12 200. Death of Date cemetary, crematory or other place)										
Pa men ury		The position of the place of Facility Lee Funeral Home, Inc 6633 Old										
permit. Departr Importe any inj		21. Signature of Funeral Service Coensee	. Name and Address of FacilityLee	Funeral H	Home,Inc 6633 01d Clinton, Maryland 20							
Physician //Medical Examiner	Examiner	shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. Ruptured Abdo Due to (or as a consequence of):  Cardiac Arrest Cardiac Arrest Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):	ominal Aortic Aneu	urysm	Iniérval Between Onset and Death							
It the death certificate be executed by the attending physician and tached for use as the burial-transit	Physiclan/Medical E	d		23d. Date of delivery Month Day Year								
eg pe		Part II. Other significent conditions contributing to death but not resulting in the un COPD	iderlying cause given in Part I.		23e. Did tobacco use contribute to the cause of death?  1 □ Yes 2 □ No 3 □ Probably 4¥€Unknow							
The law ate has b page 2 sh	Completed by	Cirrhosis		24a. Was an autopsy performed	s an 24b. Were autopsy findings available prior to completion of cause of							
e e e e e e e e e e e e e e e e e e e	tlon: To Be	25. Was case referred to medical examiner?  1	Other: 4 Nursing Ho	me 5 Tesidence 28d. Describe how in	one idence 6 □Other ( <i>Specify</i> )							
To the Hospitel or Attending within 24 hours after death within To the Funerel Director: After completely filled in by the funerel process.	Certification:	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury - At home, farm, streed building, etc. (Specify)	28f. Location (Street City or Town, St	t and Number or Rural Route Number, tate)								
ne Hospit n 24 hours ne Funere	edical	29a. Certifier  (Check only one)  1 Certifying Physicien: To the best of my knowledge, death cone)  2 Medicel Exeminer: On the basis of examination and/or inv and manner stated.	occurred at the time, date and place, estigation, in my opinion, death occurr	and due to the cause ed at the time, date	e(s) and manner as stated. and place, and due to the cause(s)							
Toth within Toth comp	Me	29b. Signature and title of certifier	29c. License number D0055086		Date signed (Month, Day, Year) April 7, 2005							
4		30. Name and address of person who completed cause of death (Item 23a) (Type, F Tong T. Ma, M.D. 11340 Penbrooke Sq	uare, #213, Waldo	rf, Maryla	and 20603							
Sta Registi		31. Date fill drywyrth, Day, Year) 32. Registrar's Signature 6 2005	•									

			T⊒ For State Registrar		Maryland		artment rtificate			and M		Reg. No.	05	14073
В	Physici	an	Decedent's Name (First, Middle,     Manager, IZ								2. Date of De Month		2005 <sup>Year</sup>	3. Time of Death
	/Medic	al	Mary Ko: 4a. Facility Name (If not institution,		abarl		Ab City 3	Four or	Location of		April		unty of Death	1:00 AM
	Examin	er	Heritage Center			ro		nda1		n Death		40.00	Baltir	0040
	Funeral			6. Sex	7. Age (In yrs. I	ast birthday)	If Under	1 Year	If Under:		8. Date of Bir	th Year)		place (State or Foreign ntry)
	Director		139-09-9226	1□M 2[X]F	10.	5 Yrs.	Months	Days	Hours	Min.	Sept 5	1899	9 Mai	yland
	pug M		Usual Residence of Decedent  10a. State 10b. County		10c. City	, Town or Lo	ocation							10d. Inside City Limits
	Manyli 4 sho	or		imore		Dur	ndalk							1 Yes 2 No
	r 28e	Director	10e. Street and Number	Imore		Dui	10f. Zip	Code				10g. Citizer	of What Cou	ntry?
	th with	alD	7232 German Hi	11 Road			2	1222				US	SA	
	r dee	Funeral	11. Marital Status	Armed For		S. 13.	Was Deced If Yes, spec	ent of His	spanic Ori	gin? (Spo	ecify Yes or No Rican, etc.)	)- 14.	Race - Ameri Black, White,	
36	rs afte	by Fi	1 ☐ Never Married 2 ☐ Marrie 3 🛣 Widowed 4 ☐ Divorced	ed 1 ∐ Yes If Yes, Giv Year or Da	e		1 ☐ Yes 2	X No	Specify:			Sp	ecity: Whit	ce
21215-0036	within 72 hours after deeth with the Maryland ene. then *neturel', or items 23a or 28e-f show the Modical Examinat mad be notified a	ted t	15. Decedent	s Education		16a. Dece	dent's Usua	l Occupa	ition			16b. Kind	of Business/Ir	dustry
215	hin 7.	ple	(Specify only highes: Elementary/Secondary (0-12)	completed) College (1	-4or 5+)	life.	kind of wor DO NOT us	e retired)	uring mosi	t of work	ing		_	_
7	ould be filed within Mental Hygiene.  Nerked other then satic event, It a M	Completed	5			Se	eamstr	ess			(P)	1	ing Ind	dustry
and	be fill Hall Had off	Be	17. Father's Name (First, Middle, L Unknown	.ast)						or's Name Unkn	e (First, Middle	, Maiden Su	тате)	
Maryland	should ind Men marke	ဥ	19a. Informant's Name/Relationsh	ip (Type, Print)		19b. Maili	na Address	(Street a		_	al Route Numb	er. City or To	own. State. Zii	Code)
	and 2 sealth ar m 27 is		Michele Jancews		niece		•				cham. M			
ře,	of Her item		20a. Method of Disposition		20b. P	lace of Disponentery, cre					Date		ion - City or T	
Ē	Pages ment of ent: If it ury or o		1 ☐ Burial 2X Cremation  4 ☐ Donation 5 ☐ Other (Sp		State	ro Cre	emator	y In	ic.					Maryland
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours atter deeth with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other then *neturel', or items 23a or 28a-1 show amy injury or other treumatic event, Ite Modical Examinal must be notified at once.		21. Signature of Funeral Service I	Jreger-	-	2	2. Name and Cremat 299 Fr	ion eder	s of Facilit Socie ick	ety Road	Of Mary Baltin	land i	Inc. Marylan	nd 21228
	Pnysician /Medical Examiner	er	23a. Part1. Enter the disease, or shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate	a. Due to (	ERO						RD/OV		ILDE E	Approximate Interval Between Onset and Death
8760,	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	dical Examiner	causé. Enter Underlying Causé (Disease or injury that initiated events resulting in death) Last	c. Due to (	or as a consequ	ience of):	(T)	041						
.O. Box 6	at the death certific by the attending pl	Physician/Med	JF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live b	come of pregnal irth 2 Tetal ant at time of de own	death 3[	⊒Ectopic pre ⊒ Other (spe					23d	. Date of deliv	ery Day Year
rds, P	w requires that the de been signed by the a should be detached f	by	Part II. Dther significant condition	ns contributing to de	eath but not resu	ulting in the u	inderlying ca	use give	n in Part I.	•		tobacco use Yes 2□N		he cause of death?
I Records,	ilclen: The law requ certilicate has been rector, page 2 shoult	Completed									24a. Was auto perfo 1 Yes		4b. Were auto prior to co death? 1 \sum Yes	opsy findings available impletion of cause of
Vital	Physicien: r this certifica ral director, i	Be	25. Was case referred to medical examiner?	Hospital:				Othe	r -/		h (Check only			
Division of	Jing Afte fune	tion: To	1 Yes 2 No  27. Mann Death 1 latural 5 Pending 2 Accident investig	28a. Date of	npatient 2  of Injury h, Day Year)	ER/Outpatie 28b. Time o Injury		Bc. Injury Work	4 <b>1</b> 7NU		me 5 ☐ Resi 28d. Describe			(y)
Divisi	To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fi	Certification:	3 Suicide 6 Could n 4 Homicide determi	ned 286. Place	of Injury - At ho ng, etc. (Specify	ome, farm, st	reet, factory	, office			28f. Location ( City or To		lumber or Rur	al Route Number,
	To the Hospitel or within 24 hours after To the Funerel Dir. completely filled in 1)	Medical (	29a. Certifier 1 Certifying (Check only one)	Physician: To the examiner: On the ba and mann	asis of examinal	wledge, deal	th occurred anvestigation,	at the tim in my op	e, date an inion, dea	d place, th occur	and due to the red at the time,	cause(s) and date and pla	d manner as s ace, and due t	stated. o the cause(s)
ı	To the vithing To the Comp	)	29b. Signature and title of certifier	1 10	(1111	11 15	1	A	number	98	=	. /	igned (Mont)	
6	1		30. Name and address of person	who completed caus	e of death (Item	23а) (Туре	, Print)	ノス	0-	PI		N=	7/	OS KMD
ď	Sta	ite	31. Date filed (Month, Day, Year)	1 32. R	egistrari Signa	ture 2	May	le	V_	1/9	ice .	Var	Sal	K MD
	Regist		ÁP	R 2 6 200	Okely	the state	2.3							

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** Janet Knight
4a. Facility Name (If not institution, give street and number) April 23 2005 /Medical 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore Greater Baltimore Medical Center Towson If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year May 28, 19 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Days Hours 1 M 2 DY 217-38-6065 63 Bermuda Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2√☐ No Baltimore Reisterstown Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 2501 Tufton Ave. 21136 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Marned 1 ☐ Yes 2 🔀 No Specify: White Baltimore, Maryland 21215-0036 Completed by 3 Widowed 4 Divorced "natural", 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within : h and Mental Hygiene.
7 is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) Housewife Homemaker 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Woodard A. Roberts, Sr. Eleanor Albrey 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Husband P.O. Box 187, Glyndon, Md. 21071 Department of Health a important: If item 27 is eny injury or other tra Larry E. Knight, Sr. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition
1 ☐ Burial 2 💆 Cremation 3 ☐ Removal from State Metro Crematory April 25, 2005 Baltimore, Md. 4 □ Donation 5 □ Other (Specify) 21. Signature of Fyperal Service License 22 Name and Address of Facility Eckhardt Funeral Chapel, P.A. 11605 Reisterstown Rd., Owings Mills, Md. 21117 23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 3 days Physician Meningitis /Medical Due to (or as a consequence of) **Examiner** Presmonia weeks Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner The law requires that the death certificate be executed use as the burial-tran Due to (or as a consequence of) P.O. Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 Tyes 2 No 3 Probably 4 Unknown Be Completed certificate has be irector, page 2 s autopsy performed? 1 Yes 2 No To the Hospital or Attending Physician: 26. Place of Death (Check only one) 25. Was case referred to medical Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? After 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: . Reompletely filled in by the f 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1x Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) edical 29a. Certifier (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D27740 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6701 North Charles St. , Towson Robert A. Palermo, GBMC M.D 32. Registrar's Signature 31. Date filed (Month, Day, Year) 0014 APR 2 6 2005 Registrar

DHMH 17 Rev 1/2001

Janet

			For State of Maryland / Dep  1 - State Registrer Ce	artment of Health and M rtificate of Death		ene 0 0 5	14075
*	Physici		1. Decedent's Name (First, Middle, Last)  NGCQQCET  KUCT	-2	2. Date of Death Month 94-22-20	Dav Ye	3. Time of Death
	/Medio Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	<i>y</i> . 22 2	4c. County of D	
			213 Church Lane	Pikesville		Baltim	
	Funeral Director		5. Social Security Number  212-01-3236  6. Sex 1 M 2 F 7. Age (In yrs. last birthday 89  Yrs.	If Under 1 Year   If Under 24 Hrs.   Months   Days   Hours   Min.	8. Date of Birth (Month, Day, 094-1	9. 9. 9. 9. 9. 9. 9. 9. 9. 9. 9. 9. 9. 9	Birthplace (State or Foreign Country) Maryland
	and W		Usual Residence of Decedent           10a. State         10b. County         10c. City, Town or L	ocation			10d. Inside City Limits
	Maryl f sho	ō					1 □Yes 2 No
	r 28a	rec	Md Baltimore Pikesv  10e. Street and Number	10f. Zip Code	10	g. Citizen of Wha	
	th with	alD	213 Church Lane	21208	U	.S.A.	
900	perritt. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Deportment of Health and Mental Hygiene. Importent: If item 27 is marked other then "natural", or Items 23a or 28a-f show any injury or other treumetic event. It s Maxified Exactions: Just be multified at ODGs.	d by Funeral Director	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces? 1 Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (Spelf Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☐ ONO Specify:	ecify Yes or No- Rican, etc.)		American Indian, Vhite, etc. <b>hite</b>
21215-0036	iithin 72 h ne. nen "natt	Completed	(Specify only highest grade completed) (Giv.  Elementary/Secondary (0-12) College (1-4or 5+)	dent's Usual Occupation e kind of work done during most of worki DO NOT use retired)	ing 1	6b. Kind of Busine	
121	lled w hygier her th		9 Sec	retary  18. Mother's Name	/First Middle M	Banking	
Maryland	d be fi	o Be	Joseph Augusta Kennedy	Molly D		iaiden Sumame)	
Z	should nd Me mark mark	은		ing Address (Street and Number or Rura		City or Town, Sta	te, Zip Code)
Š	alth a 27 is						yland 21157
altimore,	es 1 a of Hea fitem rothe		20a. Method of Disposition  1 Burial 2 Cremation 3 Removal from State  20b. Place of Disposeretry, cre	osition (Name of Imatory or other place)	Date 2	Oc. Location - City	or Town, State
Ĕ	Pagement ent: l		`4 Donation 5 Other (Specify) Lake Vie			•	e, Maryland
Balt	permit. Depart Import any inj			2. Name and Address of Facility <b>Lor</b> 728 <b>Liberty Road</b>	-		
į	The dates		23a. Part1. Enter the disease, or complications that caused the death. Do not enshock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition	Λ	or respiratory arre		Approximate Interval Between Onset and Death
	/Medical		disease or condition resulting in death)  a. Due to (or as a consequence of):		_		1 Well
	Examiner		Some distributes b Congestive	e Heart F	Tailus	2	Zweeks
	sit s	Examiner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that stiffled example)				2
_	and and II-tran	хап	c. In e of more (a) that initiated events resulting in death) Last c. Due to (or as a consequence of);				3 weeks
8760,	cate be executed physician and the burial-transit	dlcal E					
687	ificate g physas the	a)	o.				
.O. Box	The law requires that the death certific tie has been signed by the attending p page 2 should be detached for use as	Physician/M		□Ectopic pregnancy □ Other (specify)		23d. Date of Month	delivery Day Year
<u>a</u>	uires that t signed by id be detai	by	Part II. Other significant conditions contributing to death but not resulting in the in the significant conditions contributing to death but not resulting in the increase of the conditions contributing to death but not resulting in the increase of the conditions contributing to death but not resulting in the increase of the conditions contributing to death but not resulting in the increase of the conditions contributing to death but not resulting in the increase of the conditions contributing to death but not resulting in the increase of the conditions contributing to death but not resulting in the increase of the conditions contributing to death but not resulting in the increase of the conditions contributing to death but not resulting in the increase of the conditions contributing to death but not resulting in the increase of the conditions contributing to death but not resulting in the increase of the conditions contributing to death but not resulting to death but not resulti	underlying cause given in Part I.	23e. Did toba		e to the cause of death?  Probably 4Unknown
200	w requir	lete	Diabetes Mellitus		24a. Was an	24b. Were	autopsy findings available
Vital Records,		Completed	Coronary Heart Diseas	e	autopsy perform 1 Tyes 2	ed? prior deat	to completion of cause of
Vita	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to merical examiner?  Ho spital:	26. Place of Death		1	
	hys this al dii	: To	1 Yes 2 No Pospital: 1 Inpatient 2 ER/Outpatie  27. Manner of Death 28a. Date of Injury 28b. Time of		me 5 esider 28d. Describe hov	nce 6 Other (5	Specify)
O	ding Ph th. : After th funeral	tion	1 Natural 5 Pending (Month, Day Year) Injury 2 Accident investigation	Work? M 1 ☐ Yes 2 ☐ No		w injury obtained	
Division of	To the Hospital or Attending within 24 hours after death. To the Funerel Director: Afte completely filled in by the fune	Certification;	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)	reet, factory, office	28f. Location (Stre City or Town,		r Rural Route Number,
	To the Hospital or within 24 hours after To the Funerel Dir completely filled in	edical C	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, dea 2 Medical Exeminer: On the basis of examination and/or in and manner stated.	th occurred at the time, date and place, avestigation, in my opinion, death occurred	and due to the cau ed at the time, dat	use(s) and manne te and place, and	r as stated. due to the cause(s)
	To thi within To the	Me	29b. Signature and title of certifier	29c. License number	29	d. Date signed (M	onth, Day, Year)
	, , ,		Mila This	H00543	31	4/23/0	05
	5		30. Name and address of person who completed cause of death (Item 23a) (Type Richard Stefanacci DO	HOOS 43 Print) 3250 Starting (	Suite (+	- Wood	21797 bine Md
	Sta	te	31. Date filed (Month, Day, Year) 32. Megistrar's Signature	rede )			
	Registr	ar	APR 2 6 2005 Januar J. 19				

		1	For State Registrar	State of Maryland		artment of H			ene g. No.	5	140	76
	Physicis		1. Decedent's Name (First, Middle, Las	')				2. Date of Death Month	Day	Year	3. Time of	
	Physicia /Medic	al -		holos		45 O'T T			25,2005		7:30	Ам
	Examin	er	4a. Facility Name (If not institution, give 1812 Blakefield			4b. City, Town, o		Death	4c. County		1	
	Francisco I		5. Social Security Number 6. Se		ast birthday)	If Under 1 Year	If Under 24		1		lace (State o	or Foreign
	Funeral Director			XM 2□F 79	Yrs.	Months Days	Hours	Dec. 9,	1925	Gree	CE	
	pu ,		Usual Residence of Decedent  10a, State 10b, County	10c Cib	, Town or Lo	ecation				1	0d. Inside Ci	ity Limits
	shov	5			.monium						1 ☐ Yes	
	28a-1	Directo	Maryland Baltimor  10e. Street and Number	E 11	IIIOI ITUI	10f. Zip Code		10	g. Citizen of V	/hat Cour		
	3a or	ā	1812 Blakefield	Circle		21093			USA			
	death	Funeral	11. Marital Status	12. Was Decedent Ever in U. Armed Forces?	S. 13.	Was Decedent of H	lispanic Origi	n? (Specify Yes or No- Puerto Rican, etc.)		e - Americ k, White,	an Indian,	
9	tiled within 72 hours after death with the Maryland Hygiene. othar than "natural", or Items 23a or 28a-f show ant, the Medical Ever it art man be notified at	y Fu	1 ☐ Never Married 2 🛣 Married	1 ☐ Yes 2 ☐ No	1	1 ☐ Yes 2 ☑ No	Specify:	,	Specify			
Ş	hours tural',	ed by	3 ☐ Widowed 4 ☐ Divorced  15. Decedent's Ed	Year or Dates:	16a Dece	dent's Usual Occup	ation		16b. Kind of Bu			
7	in 72 inal	Completed	(Specify only highest gra-	College (1-4or 5+)	(Giva	kind of work done DO NOT use retired	during most o				,	
212	d with giene. ir that	mo	Elementary/Secondary (0-12)	College (1-401 5+)	Resta	uranteur			Restaur	ant		
nd	al Hyg	Be	17. Father's Name (First, Middle, Last)					s Name (First, Middle, M		e)		
<u>X</u>	should be find Mental His markad of	2	Elias Katholos				Smara			01-1- 71-	0-4-1	
Maryland 21215-0036	d 2 sh th and 7 is m traum		19a. Informant's Name/Relationship (7 Roula Passon	/ daughter	310 L	ochview	Terrac	or Rural Route Number, e; Luthervi	lle, MD	) 210	93	
	to and Health tem 27 other tr		20a. Method of Disposition	20b. P	lace of Dispo	osition (Name of matory or other place	cal	Date 2	20c. Location -	City or To	own, State	
ē	Pages nent of I int: If its iry or o		1 Burial 2 Cremation 3 Cremati	Removal from State   C+		rios Cem		4/27/05	Cub Hil	1, M	D	
Baltimore,	permit. Pages 1 and 2 should be tiled within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked othar than "natural; or items 23a or 28a-1 show any injury or othar traumatic avant, the Medical Ever, instructs the netitied at ODGs.		21. Signature o F neral Service Uicen			2. Name and Addre		eral Home, I			k Road 1d.2120	
			23a. Part1. Enter the disease, or comp	plications that caused the death						3011,1	Approximat	te
	r Pnysician		shock, or heart failure. List only Immediate Cause (Final disease or condition	one cause on each line.		40					Onset and	
	/Medical		resulting in death)	aDue to (or as a conseq	uence of):							
П	Examiner		Sequentially list conditions,	b								
	ed sit	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury	Due to (or as a conseq	uence of):							
	icate be executed physician and s the burial-transit	Examiner	that initiated events resulting in death) Last	c Due to (or as a conseq	uence of):							
8760,	sician buris	alE		d								
9	g phy as the	ledlo								:0		
Вох	death certificate be executed e attending physician and of for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta		⊒Ectopic pregnanc	у		23d. Dai	te of deliv	•	Year
ю. В	e deal he att	slci	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregnant at time of d	eath 5[	Other (specify)			1010		Day	T Cui
<u>G</u>	res that the de signed by the a be detached f		Part II. Other significant conditions of	ontributing to death but not res	ulting in the u	inderlying cause giv	ven in Part I.	23e. Did tob	acco use cont	ribute to t	he cause of	death?
ds,	signé d be	d by				, ,		1 □ Ye	s 2 🗆 No	3 Prob	oably 4	Unknown
Vital Records,	law requires as been sign 2 should be	Completed						24a. Was a		Were auto	psy findings	available
Re	9 <del>-</del> 9	dwo						autops perform	ned?	death?	mpletion of o	ause of
ta	ician: Th certificate rector, pag	a	25. Was case referred to medical				26. Place	of Death (Check only on				
of V	Physician: this certific ral director,	To B	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatie	nt 3□ DOA Ott	ner: 4 □ Nur	sing Home 5 Peside			(y)	
n o	Ing PI		27. Man or of Death 1 atural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Wo	rk?	28d. Describe ho	w injury occur	red		
sio	ttandl death tor: /	icatl	2 Accident investigation 3 Suicide 6 Could not b		ome farm et		]Yes 2□N	28f. Location (St.	reet and Numb	er or Run	al Route Nun	nber.
Division	after of Direction by	ertification;	4 Homicide determined	building, etc. (Specif	(y)	reet, ractory, ornos		City or Town				
	To the Hospital or Attanding Phys within 24 hours after death.  To the Funaral Director: After this v completely filled in by the funeral dir	ledical C	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exar	ysician: To the best of my kno niner: On the basis of examina and manner stated.	owledge, dea ation and/or in	th occurred at the tinvestigation, in my	me, date and opinion, death	place, and due to the ca h occurred at the time, d	ause(s) and ma ate and place,	anner as s and due t	stated. o the cause(s	s)
	Fo the vithin Fo that complex	Me	29b. Signature and title of certifier	000	_	29c. Licens	se number	2	9d. Date signe	d (Month,	Day, Year)	
			Mal	NEW		D,	1923	1	4/20	105		
	6		30. Name and address of person who	completed cause of death (Iter	710	100/01	26.	Town.	hed ?	212	04	
:.		ate	31. Date filed (Month, Day, Year)	32. Registrar's Signa 1 PR 2 6 2005	Marie	, & A	and)					
	Regist	rar	716105	ALK & DATOR	O Carres							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 2:40 Jerome Joseph Kahl 2005 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b, City, Town, or Location of Death Examiner ar If Under 24 Hrs. Bellic Hea Mariner If Under 1 Year Months Days 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 1 XM 2 ☐ F 218-07-6755 Yrs. Director 1. 1916 Marvland Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits th and Mental Hygiene.
?? Is marked other than "natural", or Items 23s or 28s-f show transitic event, Ite Medical Examinations to rediffed all Maryland Harford Abingdon 1 ☐ Yes 2 No Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 2909 Silver Spruce Lane 21009 Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status Yes 2 □ No Yes, Give ∕ear or Dates: 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Carpenter Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Henry William Kahl Catherine Rosa Butt 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other transpace. Catherine A. Keller/Daughter 2909 Silver Spruce Lane, Abingdon, MD 21009 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Bel Air Mem. Gardens | 04-25-05 Bel Air, MD 22. Name and Address of Facility
McComas Funeral Home, P.A.

→ 1317 Cokesbury Road, Abingdon, MD 21. Sign de Licensee 21009 or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ist only one cause on each line. 23a. Part1. Enter the disease, shock, or leart failure. Li Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Multi-infanct Dimintin Physician YIANS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): burial-P.O. Box 68760. Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐ Pregnant at time of death 5 Other (specify) should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2□ No 24a. Was an autopsy performed? Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other. 1 ☐ Yes 2024No 2 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) After thi 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? Medical Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No I Director: A investigation 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specily) 4 Thomicide within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29b. Signature and title of certifier Type, Print)

Ayenus Bil Air Mary (4nd 210) Y

Spale

State

Registrar

31. Date filed (Month, Day, Year) APR 2 6 2005

DHMH 17 Rev 1/2001

			1- State of Maryland / Department of Health are Certificate of Death	nd Menta		erie () (	)5	14078
	Physici	an	1. Decedent's Name (First, Middle, Last)  Eva L. Kalister	Mon	of Death	Day 21	Year 2005	3. Time of Death 2:20 P. M
	/Medic Examin		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of I	Death Apr	. 1 1		y of Death	2:20 P. ···
	Exami		Genesis Eldercare Hammonds Lane Baltimore			Ann	e Aru	ndel
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24  216 20 8883 1   M 2   XF 77 Yrs.   Months Days Hours	Min. 8. Date	of Birth oth, Day, Y	'ear)	9. Birth	place (State or Foreign ntry)
	Director		216 20 8883 1 M 2 LAF 77 Yrs. Substitution of Decedent	Nov	. 28,	1927	Mar	yland
	yland how		10a. State 10b. County 10c. City, Town or Location					10d. Inside City Limits
	a Mar	Director	Maryland Baltimore Baltimore					1 ☐ Yes 2X No
	with th		10e. Street and Number 10f. Zip Code		100	g. Citizen of		ntry?
	ns 23	Funeral	2807 Alabana Avenue 21227  11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin	n? (Specify Yes	or No-	U.S		can Indian,
ဖွ	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is merked other then "natural", or Items 23e or 28e-f show aumatic event, Ite Medical Ever fine from the rectified at	Fun	Armed Forces? If Yes, specify Cuban, Mexican, F	Puèrto Rican, e	tc.)	Bla	ick, White,	etc.
Maryland 21215-0036	ural',	d by	3 AWidowed 4 Divorced Year or Dates:				か: Whi	
5	in 72 in 72 in at	Completed	15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of life. DO NOT use retired)	of working	16	Sb. Kind of E	Business/In	dustry
212	d withi	omb	9th College (1-4or 5+) Homemaker			Ow	n Hom	ie
2	al Hyg	Bec		s Name (First, A			тө)	
<u>X</u>	Ment Ment	Jo		ary E. (				
ā Z	d 2 st th and t7 Is n traun	10	19a. Informant's Name/Relationship ( <i>Type, Print</i> )  Martin Kalister / son  19b. Mailing Address ( <i>Street and Number of Street and Numbe</i>					
ē,	permit. Pagas 1 and 2 should be Department of Health and Menta Important: If Itam 27 Is marked any injury or other traumatic evense.		20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	-	c. Location		
altimore,	Paga nent o unt; If ury or		I Li bunar 2 Micromation 3 Linemoval from State	/25/2005	; В	altimo	ore,	Maryland
Balt	epartr epartr nporta ny inju		21. Signature of Funeral Service Licensee 22. Name and Address of Facility					-
_	<u></u> 0 ≒ 6 0		Syrve grammousk 4001 Ritchie Hig				Mary	
	6		23å. Part1. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as call shock, or heart failure. List only one cause on each line.  Immediate Cause (Final					Approximate Interval Between Onset and Death
	Enysician /Medical		Immediate Cause (Final disease or condition resulting in death)  a.   CANCINDA BACAST  Due to (or as a consequence of):	DUICH	- //	EIS		
	Examiner		$A\Lambda$					
1	si ad	iner	if any, leading to immediate cause. Enter Underlying					
	xacut	Examiner	Cause (Disease or injury that initiated events resulting in death) Last c. Due to (or as a consequence of):					
8760	The law requires that the death certificate be exacuted the has been signed by the attending physician and page 2 should be detached for use as the burial-transit	dicai E	d					
89	intifical ing phi	Medi	IF FEMALE:					
Rox	eath certific attending p	Physician/Me	23b. Was decedent pregnant in the past 12 morths?				ite of delive onth	ery Day Year
o.	at the de by the a tached	ysic	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 ☐ Other (specify)9 ☐ Unknown 9 ☐ Unknown					
 J	res that igned b be deta	by Pt	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e.	Did tobac	cco use con	tribute to t	ne cause of death?
ecords,	w require been sig should b			_	1 🗌 Yes	2 🗆 No	3 Prob	pably 4 Donknown
ecc	e law n has be je 2 sh	Completed		24a.	Was an autopsy	24b.	Were auto	psy findings available mpletion of cause of
al R				10	performe Yes 2 🛚	مر ?'d	death?	2 No
Vital	sician: certific lirector,	o Be	examiner?	f Death <i>(Check</i> ing Home 5		0 70"		
10	ding Phys h. After this funeral di	$\vdash$	27. Manney of Death 28a. Date of Injury 28b. Time of 28c. Injury at			injury occur		y)
Division	uttandin death. ctor: Af y tha fur	catic	2 Accident investigation M 1 Yes 2 No					
<u> </u>	or Attanated after deatl	Certification:	3 ☐ Suicide 4 ☐ Homicide  4 ☐ Homicide  4 ☐ Could not be determined  28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify)		tion (Stree or Town, S		er or Rura	I Route Number,
_	spital		29a. Certifier  (Check only 20 Modified Systems 20 the best of my knowledge, death occurred at the time, date and p	place, and due t	o the caus	se(s) and m	anner as s	tated
	To the Hospital or Attending Physicien: Within 24 hours after deactor: After this certific completely filled in by the funeral director,	Medical	(Check only one)  2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death of and manner stated.	occurred at the	time, date	and place,	and due to	the cause(s)
	To t To tl	Σ	29b. Signature and title of certifier  29c. License number			Date signe		
			Almhy A. CHATTENS 23585	ν 	1	4-2	-6-	0>
	10		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  3927, ANNA POW North 2127	7				
	Sta		31. Date liled (Month, Day, Year) 38 Registrar's Signature	<b>-</b>				
	Registr	ar	APR 2 6 2005 January 1					

			For State Registrar	State of Marylar		artment of H rtificate of I			giene 0	15	14079
	0		1. Decedent's Name (First, Middle, Last)	u Klein				2. Date of Dea		Year	3. Time of Death
	Physicia /Medic	al	Bruno Harr	7	nani			April	18, 2	2005	7:39 pm
	Examin	er	4a. Facility Name (If not institution, give s Shady 6 vove Ad		pital	4b. City, Town, or Rockvil	Location of Death	n .	4c. County Montg		37
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs.		If Under 1 Year	If Under 24 Hrs.		h	9. Birthp	lace (State or Foreign
	Director		3,7 .0 ,703	M 2□F 79	Yrs.	Months Days	Hours Min.	September	r 19, 1925	Lat	
	land		Usual Residence of Decedent  10a. State 10b. County	10c. Ci	ty, Town or Lo	ocation				1	0d. Inside City Limits
	a-fsh	ctor	Maryland Montgome	ry	Gaithe	rsburg					1 ☐ Yes 2 📉 No
	or 28	Dire	10e. Street and Number			10f. Zip Code			10g. Citizen of V	Vhat Cour	ntry?
	eath v	eral	912 West Side Dri	Ve 12. Was Decedent Ever in U	IS 13	Was Decedent of H	)878 ispanic Origin? (S	necify Yes or No	Latvia		ean Indian.
36	perniit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "neturel", or items 23a or 28a-f show any injury or other treumetic event, the Medical Evartified must be rediffed at ADES.	by Funeral Director	1 Never Married 2 Married 3 Widowed 4 ADivorced	Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates:		lf Yes, specify Cuba 1 ☐ Yes 2 🔯 No	Specify:	o Rican, etc.)		k, White,	
21215-0036	72 hou	Completed	15. Decedent's Edu (Specify only highest grade		16a. Dece	dent's Usual Occup	ation	rkina	16b. Kind of Bu	usiness/In	dustry
121	within ne.	mple	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retired	1)	, and	Archite	otur	ol Firm
	filed with Hygiene. other ther		17. Father's Name (First, Middle, Last)		Selli	.01 ASSUCI		me (First, Middle,			al FIFIII
<u>lan</u>	Mental arked o	To Be	Alfred Edward Kle	imanis			Elvira	Pihka			
Maryland	2 should I and Meni is marker		19a. Informant's Name/Relationship (Ty			ng Address (Street			-	-	
e)	s 1 and 2 if Health a item 27 is other treu	1	Bruno A. Kleimanis 20a. Method of Disposition	,		lest Side	Drive, G	Date	ourg, Ma		
Baltimore,	permit. Pages 1 Deportment of P Importent: If ite any injury or ot		1 Burial 2 □ Cremation 3 □ R  4 □ Donation 5 □ Other (Specify)	emoval from State	cemetery, cre ck Cree	matory or other place ek Cemeter	У 200	1 25, )5	Washing	ton,	D.C.
Bai	permit Depar Impor any in		21. Signature of Fun and Servina Uicenson	M013	305 Ro	2. Name and Address bert A. Pum O West Mont	ss <sub>o</sub> d Facility Iphrey Fune Igomery Ave	eral Home/ enue, Rock	Rockville ville, Mar	, Inc.	20850-2805
П			23a. Part1. Exer the disease, or complishock, or heart failure. List only or	cations that caused the dea ne cause on each line.	th. Do not en	ter the mode of dyin	g, such as cardiad	or respiratory a	rest,		Approximate Interval Between Onset and Death
	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)	Acute 1		rdial	Intan	tion		1	mmediate
	Examiner			Coronary	Av Le	W Dis	ease				Vears
-	D ==	Iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consec	quence of):					1	
′ _	xecute and II-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (of as a consec	Mole!	sterole	mia				years
38760,	icate be executed physician and s the burial-transit	dicalE	L,	1	. ,					'	<b>,</b>
~		w	IF FEMALE:								
P.O. Box	that the death certif ted by the attending detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 Unknown	3c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of 9 ☐ Unknown	al death 3	Ectopic pregnancy Other (specify)	,		23d. Dat Mo	te of delive inth	ery Day Year
	law requires that the as been signed by th 2 should be detache	by Ph	Part II. Other significant conditions con	ntributing to death but not re-	sulting in the u	ınderlying cause gıv	en in Part I.	23e. Did t	obacco use cont	ribute to t	ne cause of death?
ord	w require been sig should b							1 🗆 '	res 2.XNo	3 Prot	pably 4 Unknown
Vital Records,	The ate ha	Completed				<del></del>		24a. Was autor perfo	rmed?	prior to co death?	psy findings available mpletion of cause of 2 M No
Vita	Attending Physicien: Th r death. sctor: After this certificate by the funeral director, pag	Be	25. Was case referred to medical examiner?	lospital:		Oth		ath (Check only o			
of	Phys r this eral dir	: To	1 ☐ Yes 2 No  27. Manner of Death	28a. Date of Injury	ER/Outpatie	nt 3 DOA	er: 4 Nursing F		dence 6 Oth		y)
ion	ttending F death. ctor: After y the funera	atlor	1 X Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury	Wor	k? Yes 2 □ No				
Division	after des Directo	ertification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At I building, etc. (Spec	nome, farm, st	reet, factory, office		28f. Location (: City or Tox		er or Rura	al Route Number,
	To the Hospitel or Attenwithin 24 hours after deatl To the Funeral Director:	edical C	29a. Certifier 1 Certifying Phy (Check only one) 1 Medicel Exemi	sician: To the best of my kn ner: On the basis of examin and manner stated.	owledge, deal ation and/or in	th occurred at the tin	me, date and place pinion, death occu	e, and due to the urred at the time,	cause(s) and ma date and place,	anner as s and due to	tated. o the cause(s)
	Withi To tl	Ž	29b. Signature and title of certifier	61/11		29c. Licens	e number	,	29d. Date signer	d (Month,	Day, Year)
,			- Yamara	JKILL O	- 02-1 ~	770	03/19	/	Itpril	18	, 2005
	18		30. Name and address of person who co Tamava L-Kile, C	ompleted cause of death (Ite	m 23a) (Type,	( Center	Drive E	Pockvil	le Mi)	20	850
*	Sta Regist		31. Date filed (Month, Day, Fear)	32. Registrar's Sign 2 6 2005	ature	1 ford	1				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** :30 D /Medical 4a. Facility Name (It not institution, give street and number 3719 Fieldstyne Ruad 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore baltimore Date of Birth Month, Day, Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State Country) **Funeral** Days Months Min 10 M 20 F Director (n Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "neturel", or items 23s or 28s-1 show other treumstic event, the Mudical Examiner must be notified at Baltimore 1 ☐ Yes 2 No Director 10e. Street and Number 10g. Citizen of What Country? Funeral . Was Decedent Ever in U.S. Armed Forces? 1 MyYes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No ρ Specify: 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) intenance 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Clyde W. Lewis SR 19aj Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number of Rural Rute Number, City or Town, State, Zip Code) William Fieldsto 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Pages 1 Department of H Important: If ite any injury or ot once. cemetery 1 Burial 2 Cremation 3 Removal from State Kaltimore 14 ☐ Donation 5 ☐ Other (Specify) Jood (aum) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Vaugus C Greene Funeral Spruces Tanolalistown MD 2/133
iac or respiratory arrest, Approximate Interval Between Onset and Death Rol! aug 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failule. List only one cause on eighline. Immediate Cause (Final Physician LINS MONTE disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) the Hospitel or Attending Physicien: The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 Onknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an 2 No 1 Yes Be 25. Was case reterred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Mesidence 6 Other (Specify) 2 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death Certification: 28d. Describe how injury occurred Injury at Work? 1 Natural 5 Pending investigation 1 Yes 2 Accident after death Director: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Thomicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical 29b. Signature 29d. Date signed (Month, Day, Year) 29c. License number

Registrar

DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

APR 2 6 2005

pleted cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

D35398

21117

23 Cross Roads Dr. Owings Mill MD

			For State Registrar	State of	f Maryla		artment of Hortificate of L			giene () () Reg. No.	5	14081
	Di		1. Decedent's Name (First, Middle, Last)		<u> </u>				2. Date of Dea	ath Day	Year	3. Time of Death
	Physicia /Medic		SARAH E.	LANDO	N				April_	20	2005	6:13 A <sup>M</sup>
	Examin		4a. Fecility Name (If not institution, give s	treet and nur	nber)		4b. City, Town, or	Location of Death		4c. County		
П			Laurel Regional				Laure		0.5	Princ		
	Funeral		5. Social Security Number 6. Sex	M 2 <b>X</b> F		s. last birthday)  Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da Feb. 7,	v. Year)	Cour	lace (State or Foreign htry) rland
h	Director		215-32-6187		8	35 Yrs.			reb. /,	1920	нагу	Tand
	and It		10a. State 10b. County		10c. 0	City, Town or Lo	ocation				1	0d. Inside City Limits
	Mary	jo	MD Prince Ge	orge's	T.a	urel						1 XX es 2 □ No
	the 28a	Director	10e. Street and Number	0190 0	,	4101	10f. Zip Code			10g. Citizen of	What Cour	ntry?
	3e or		41 B Street				2070	7		USA		
	me 2	Funeral		2. Was Dece	edent Ever in	U.S. 13.	Was Decedent of Hi If Yes, specify Cuba	spanic Origin? (Sp	ecify Yes or No	- 14. Rac	ce - Americ	
٥	or Ita		1 Never Married 2 Married	Armed Fo 1 ☐ Yes If Yes, Giv	2 🔀 No		1 ☐ Yes 2 No	Specify:	rusan, story		y: Whi	
<u></u>	hours after death with the Maryland turel', or Itame 23e or 28e-f ehow al Ezam ner must be motified at	d by	3 ⊠ Widowed 4 □ Divorced	Year or D	ates:		163 263110	эрвену.				
21215-0036	72 h	Completed	15. Decedent's Edu (Specify only highest grade	cation completed)		16a. Dece (Give	dent's Usual Occupa kind of work done of DO NOT use retired,	ation furing most of work	ring	16b. Kind of B	usiness/In	dustry
2	athin Jan.	Idu	Elementary/Secondary (0-12)	College (1	1-4or 5+)	1		)		01.70	Home	
7	led w lygiel her ti	ខ	9th 17. Father's Name (First, Middle, Last)	Ø		НОІ	memaker	18. Mother's Nam	e (First Middle		Home	
ano	be fi	Be								nia Sim		
<u>~</u>	J Mer narke	2	Edward Walter Gor  19a. Informant's Name/Relationship (Ty			19h Maili	ng Address (Street a					(Code)
Maryland	12 st h and 7 is n traur		Louise Golden/Daug				ross Stree			20723	,	,
25	s 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene from them 23 or 28s-1 show them 27 is marked other than "natural", or Itame 23e or 28s-1 show other traumatic event, "in Mardical Exam per must be notified at		20a. Method of Disposition		206	12.	osition (Name of matory or other place		Date	20c. Location	- City or To	own, State
کّ	nt of		1 Burial 2 □ Cremation 3 □ P	emoval from	State		matory or other place Cemetery		/2005	Laur	el, M	(D
altimore,	it. Pi		<ul> <li>4 □ Donation 5 □ Other (Specify)</li> <li>21. Signature of Funeral Service License</li> </ul>	3e	110		2. Name and Addres				-	
Ba	permit. Pages 1 Department of H Importent: If Ite any injury or otl once.		Jamino #	Mon	Y MOILO		313 Talbo				2070	
	_		23a. Part1. Enter the disease, or complishock or heart failure. List only or	cations that o	<b>N</b>		ter the mode of dying	g, such as cardiac	or respiratory a	rrest,		Approximate Interval Between
			Immediate Cause (Final								т.	Onset and Death
	Pnysician /Medical		disease or condition resulting in death)		cute My (oras a cons		al Infarct	cion				less l year
	Examiner						ic Cardio	vascular	Disease	1	(	ver 5 years
	600	ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying		(or as a cons		20 002020					
	uted d ansit	듣	Cause (Disease or injury that initiated events									
o Î	exec an an rial-tr	Exa	resulting in death) Last	Due to (or as a consequence of):								
8760,	cate be executed physician and the burial-transit	dical Examiner		i						··	0.	
9			IF FEMALE:								20	
Box	death certifii attending p	an/	23b. Was decedent pregnant		tcome of preciping	etal death 3	□Ectopic pregnancy				ate of delive onth	ery Day Year
о. Ш	e dea he at ned fo	SICI	in the past 12 months? 1 □ Yes 2 ② No 9 □ Unknown	4☐ Pregi 9☐ Unkn	nant at time o lown	f death 5	Other (specify)					
<u>Ч</u>	The law requires that the death certif ite has been signed by the attending page 2 should be detached for use a	by Physician/Me	Part II. Other significent conditions co.	atributing to d	leath but not a	resulting in the	underlying cause give	en in Part I	23e. Did 1	tobacco use cor	tribute to t	he cause of death?
	ires tha signed		Part N. Other significant conditions co.	itilibating to a	oddi bachoch		and any mag adda as a			Yes 2XXNo		oably 4 Unknown
Vital Records,	w requir been si should	Completed							24a. Was	24h	More out	opsy findings available
ec	e law has t	ldu							auto		prior to co	impletion of cause of
三	: The cate								1 Yes	2 <b>∑</b> No	1 🗌 Yes	2 🔀 No
/ita	ician Sartifi ector	Be	25. Was case referred to medical examiner?	lospital:		22.7	Oth	26. Place of Dea				
of	Physician: The la r this certificate has real director, page 2	2	1 Yes 2 No	28a. Date		ZER/Outpatie	ant 3 DOA	4   Nursing H		idence 6 Ot how injury occu		TY)
n C	ling I	lon	1 Natural 5 ☐ Pending	(Mor	nth, Day Year	) Injury	Wor	k? Yes 2 □ No				
<u>S</u>	death death ctor: / the	ical	3 Suicide 6 Could not be	28e. Plac	e of Injury - A	t home, farm, s	treet, factory, office				ber or Rur	al Route Number,
Division	after Direct In by	Certification:	4 Homicide determined		ling, etc. (Spe		,		City or To	wn, State)		
_	To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral di		29a. Certifier 11 Certifying Phy	sician: To th	e best of my l	knowledge, dea	th occurred at the tin	me, date and place	, and due to the	cause(s) and n	nanner as s	stated.
	e Hor 24 h e Fur	edical	(Check only 2 Medical Exami	ner: On the t and mar	pasis of exam nner stated.	ination and/or i	nvestigation, in my o	pinion, death occu	rred at the time,	, date and place	, and due t	o the cause(s)
	ro th vithin ro th	₹ E	29b. Signature and title of certifier	64	>		29c. Licens	e number		29d. Date sign	ed (Month,	Day, Year)
)	, ,,,,,		1	the	-0,	W.	\ <u></u>	D24721		April	21, 2	2005
	N		30. Name and address of person who c									
_	1/		Syed Sadiq, 143	33 Lau:	rel-Bo	wie Roa	d, Laurel	, MD 20	/08			
		ate	31. Date filed (Month, Apr Pear 2 6	200532.	Registrar's Si	gnature	Speli					
	Regist	rar			121		9					

Physician   March	1. Decedent's Name (First, Middle, Last)   FRANCES FOOTE LEMOINE   2. Date of Death Day Year   3. Time of Death Pril 24, 2005   9:15P M
FRANCES FOOTE LEMOINE  April 24, 2005 9:15P	FRANCES FOOTE LEMOINE  4a. Facility Name (if not institution, give street and number) 800 Southerly Road #1211  5. Social Security Number   6. Sax   7. Age (in yrs. last birthday)   11 Under 1 Year   11 Under 24 Hrs.   8. Date of Birth   Days   September   16, 1920   Septemb
Southerly Road #1211   Towson   Southerly Road #1211   Southerly Road #1211   Southerly Road #1211   Southerly Road #1211   Towson   Southerly Road #1211   Towson   Southerly Road #1211   Towson	800 Southerly Road #1211  5. Social Security Number   6. Sex   7. Age (In yrs. last birthday)   HUnder 1 Year   HUnder 24 His.   8. Date of Birth   2
Function Director Dir	S. Social Security Number   214-14-9558   6. Sex   1
214-14-9558   1   M 2   X 84   Yrs   Months   Days   Hours   Mr.   September 16, 1920   Maryland   Inc. City, Town or Location   102. City, Town or Location   103. State   104. Country   105. State   105. Country   105. Country   105. State	214-14-9558   1
10a. State   10b. County   10c. City, Town or Location   10d. Inside City Limit   10d. Inside	10a. State   10b. County   10c. City, Town or Location   10d. Inside City Limits   1   Yes   X   No   No   10d. Inside City Limits   1   Yes   X   No   No   10d. Street and Number   10d. City Code   10d. Citizen of What Country?   10d. Inside City Limits   1   Yes   X   Ximage   10d. Citizen of What Country?   10d. Inside City Limits   1   Yes   Ximage   10d. Citizen of What Country?   10d. Citizen of North Citizen of What Country?   10d. Citizen of North Citizen
17. Father's Name (First, Middle, Last)  Irving Nelson Foote  19a. Informant's Name/Relationship (Type, Print)  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  William F.C. Marlow Jr Son 404 Allegheny Avenue Towson, Maryland 21204  20a. Method of Disposition  1 Burial 2XX cremation 3 Removal from State comelegy, crematory or other place)  1 Baltimore, Maryland  20b. Place of Disposition (Name of Comelegy, Crematory or other place)  1 Baltimore, Maryland  20c. Location - City or Town, State  20a. Method of Disposition  1 Burial 2XX cremation 3 Removal from State  20a. Method of Disposition  20a. Method of Disposition  1 Burial 2XX cremation 3 Removal from State  20c. Location - City or Town, State  20c. Location - City	Maryland Baltimore   Towson
17. Father's Name (First, Middle, Last)  Irving Nelson Foote  19a. Informant's Name/Relationship (Type, Print)  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  William F.C. Marlow Jr Son 404 Allegheny Avenue Towson, Maryland 21204  20a. Method of Disposition  1 Burial 2XX cremation 3 Removal from State comelegy, crematory or other place)  1 Baltimore, Maryland  20b. Place of Disposition (Name of Comelegy, Crematory or other place)  1 Baltimore, Maryland  20c. Location - City or Town, State  20a. Method of Disposition  1 Burial 2XX cremation 3 Removal from State  20a. Method of Disposition  20a. Method of Disposition  1 Burial 2XX cremation 3 Removal from State  20c. Location - City or Town, State  20c. Location - City	800 Southerly Road #1211    21286
17. Father's Name (First, Middle, Last)  Irving Nelson Foote  19a. Informant's Name/Relationship (Type, Print)  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  William F.C. Marlow Jr Son 404 Allegheny Avenue Towson, Maryland 21204  20a. Method of Disposition  1 Burial 2XX cremation 3 Removal from State comelegy, crematory or other place)  1 Baltimore, Maryland  20b. Place of Disposition (Name of Comelegy, Crematory or other place)  1 Baltimore, Maryland  20c. Location - City or Town, State  20a. Method of Disposition  1 Burial 2XX cremation 3 Removal from State  20a. Method of Disposition  20a. Method of Disposition  1 Burial 2XX cremation 3 Removal from State  20c. Location - City or Town, State  20c. Location - City	800 Southerly Road #1211
17. Father's Name (First, Middle, Last)  Irving Nelson Foote  19a. Informant's Name/Relationship (Type, Print)  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  William F.C. Marlow Jr Son 404 Allegheny Avenue Towson, Maryland 21204  20a. Method of Disposition  1 Burial 2XX cremation 3 Removal from State comelegy, crematory or other place)  1 Baltimore, Maryland  20b. Place of Disposition (Name of Comelegy, Crematory or other place)  1 Baltimore, Maryland  20c. Location - City or Town, State  20a. Method of Disposition  1 Burial 2XX cremation 3 Removal from State  20a. Method of Disposition  20a. Method of Disposition  1 Burial 2XX cremation 3 Removal from State  20c. Location - City or Town, State  20c. Location - City	11. Marital Status   12. Was Decedent Ever in U.S. Armed Forces?   13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, Specify Cuban, Mexican, Puerto Rican, etc.)   14. Race - American Indian, Black, White, etc.   17 yes 200   15. Decedent's Education (Specify only highest grade completed)   16a. Decedent's Usual Occupation (Give kind of work done during most of working life. Do NoT use retired)   16b. Kind of Business/Industry   16b. Kind of B
17. Father's Name (First, Middle, Last)  Irving Nelson Foote  19a. Informant's Name/Relationship (Type, Print)  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  William F.C. Marlow Jr Son 404 Allegheny Avenue Towson, Maryland 21204  20a. Method of Disposition  1 Burial 2XX cremation 3 Removal from State comelegy, crematory or other place)  1 Baltimore, Maryland  20b. Place of Disposition (Name of Comelegy, Crematory or other place)  1 Baltimore, Maryland  20c. Location - City or Town, State  20a. Method of Disposition  1 Burial 2XX cremation 3 Removal from State  20a. Method of Disposition  20a. Method of Disposition  1 Burial 2XX cremation 3 Removal from State  20c. Location - City or Town, State  20c. Location - City	Specify: Wille   Spec
17. Father's Name (First, Middle, Last)  Irving Nelson Foote  19a. Informant's Name/Relationship (Type, Print)  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  William F.C. Marlow Jr Son 404 Allegheny Avenue Towson, Maryland 21204  20a. Method of Disposition  1 Burial 2XX cremation 3 Removal from State comelegy, crematory or other place)  1 Baltimore, Maryland  20b. Place of Disposition (Name of Comelegy, Crematory or other place)  1 Baltimore, Maryland  20c. Location - City or Town, State  20a. Method of Disposition  1 Burial 2XX cremation 3 Removal from State  20a. Method of Disposition  20a. Method of Disposition  1 Burial 2XX cremation 3 Removal from State  20c. Location - City or Town, State  20c. Location - City	17. Father's Name (First, Middle, Last)  Irving Nelson Foote  19a. Informant's Name/Relationship (Type, Print)  William F.C. Marlow Jr  Son  404 Allegheny Avenue Towson, Maryland 21204  20a. Method of Disposition  1 Burial 2XX remation 3 Removal from State  20b. Place of Disposition (Name of cometery, crematory or other place)  1 Burial 2XX remation 3 Removal from State  20c. Location - City or Town, State  20c. Location - City or
17. Father's Name (First, Middle, Last)  Irving Nelson Foote  19a. Informant's Name/Relationship (Type, Print)  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  William F.C. Marlow Jr Son 404 Allegheny Avenue Towson, Maryland 21204  20a. Method of Disposition  1 Burial 2XX cremation 3 Removal from State comelegy, crematory or other place)  1 Baltimore, Maryland  20b. Place of Disposition (Name of Comelegy, Crematory or other place)  1 Baltimore, Maryland  20c. Location - City or Town, State  20a. Method of Disposition  1 Burial 2XX cremation 3 Removal from State  20a. Method of Disposition  20a. Method of Disposition  1 Burial 2XX cremation 3 Removal from State  20c. Location - City or Town, State  20c. Location - City	17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Maiden Sumane)  19a. Informant's Name/Relationship (Type, Print)  William F.C. Marlow Jr  Son  404 Allegheny Avenue Towson, Maryland 21204  20a. Method of Disposition  1 Burial 2XX remation 3 Removal from State cometery, crematory or other place)  1 Burial 2XX remation 3 Removal from State cometery, crematory or other place)  1 Ignature of Funeral Service Licensee  22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home Inces 6500 York Road Baltimore, Maryland 21212
17. Father's Name (First, Middle, Last)  Irving Nelson Foote  19a. Informant's Name/Relationship (Type, Print)  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  William F.C. Marlow Jr Son 404 Allegheny Avenue Towson, Maryland 21204  20a. Method of Disposition  1 Burial 2XX cremation 3 Removal from State comelegy, crematory or other place)  1 Baltimore, Maryland  20b. Place of Disposition (Name of Comelegy, Crematory or other place)  1 Baltimore, Maryland  20c. Location - City or Town, State  20a. Method of Disposition  1 Burial 2XX cremation 3 Removal from State  20a. Method of Disposition  20a. Method of Disposition  1 Burial 2XX cremation 3 Removal from State  20c. Location - City or Town, State  20c. Location - City	17. Father's Name (First, Middle, Last)  Irving Nelson Foote  19a. Informant's Name/Relationship (Type, Print)  William F.C. Marlow Jr  Son  404 Allegheny Avenue Towson, Maryland 21204  20a. Method of Disposition  1 Burial 2XX remation 3 Removal from State  20b. Place of Disposition (Name of cometery, crematory or other place)  1 Burial 2XX remation 3 Removal from State  20c. Location - City or Town, State  20c. Location - City or
Physician /Medical Examiner  23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):	Irving Nelson Foote  19a. Informant's Name/Relationship (Type, Print)  William F.C. Marlow Jr Son 404 Allegheny Avenue Towson, Maryland 21204  20a. Method of Disposition  1 Burial 2XX Cremation 3 Removal from State  1 Donation 5 Other (Specify)  21. Ignature of Funeral Service Licensee  22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home Inc  6500 York Road Baltimore, Maryland 21212
Physician /Medical Examiner  23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  William F.C. Marlow Jr Son 404 Allegheny Avenue Towson, Maryland 21204  20a. Method of Disposition  1 Burial 2XX Cremation 3 Removal from State  1 Date 20c. Location - City or Town, State cemetery, crematory or other place)  1 Date 20c. Location - City or Town, State 20c. Location
Physician /Medical Examiner  23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):	William F.C. Marlow Jr Son 404 Allegheny Avenue Towson, Maryland 21204  20a. Method of Disposition    Date   Date   20c. Location - City or Town, State   20c. Location - City or Town,
Physician /Medical Examiner  23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):	20a. Method of Disposition    Date   20c. Location - City or Town, State
Physician /Medical Examiner  23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):	GreenMount Cemetery 4/26/05  Baltimore, Maryland  21 Ignature of Funeral Service Licensee  22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home Inc  6500 York Road Baltimore, Maryland 21212
Physician /Medical Examiner  23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):	21/ Ignature of Funeral Gervice Licensee 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home Inc 6500 York Road Baltimore, Maryland 21212
Physician //Medical Examiner  23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Due to (or as a consequence of):	
Immediate Cause (Final disease or condition resulting in death)  Immediate Cause (Final disease or condition resulting in death)  Immediate Cause (Final disease or condition resulting in death)  Immediate Cause (Final disease or condition resulting in death)  Immediate Cause (Final disease or condition resulting in death)  Immediate Cause (Final disease or condition resulting in death)  Immediate Cause (Final disease or condition resulting in death)  Immediate Cause (Final disease or condition resulting in death)  Immediate Cause (Final disease or condition resulting in death)  Immediate Cause (Final disease or condition resulting in death)  Immediate Cause (Final disease or condition resulting in death)  Immediate Cause (Final disease or condition resulting in death)  Immediate Cause (Final disease or condition resulting in death)  Immediate Cause (Final disease or condition resulting in death)  Immediate Cause (Final disease or condition resulting in death)  Immediate Cause (Final disease or condition resulting in death)  Immediate Cause (Final disease or condition resulting in death)  Immediate Cause (Final disease or condition resulting in death)  Immediate Cause (Final disease or condition resulting in death)  Immediate Cause (Final disease or condition resulting in death)  Immediate Cause (Final disease or condition resulting in death)  Immediate Cause (Final disease or condition resulting in death)  Immediate Cause (Final disease or condition resulting in death)  Immediate Cause (Final disease or condition resulting in death)  Immediate Cause (Final disease or condition resulting in death)  Immediate Cause (Final disease or condition resulting in death)  Immediate Cause (Final disease or condition resulting in death)  Immediate Cause (Final disease or condition resulting in death)  Immediate Cause (Final disease or condition resulting in death)  Immediate Cause (Final disease or condition resulting in death)  Immediate Cause (Final disease or condition resulting in death)  Immediate Cause (Final disease	23a. Part1. Enter the disease, or comprications that caused the death. Do not enter the mode or dying, such as cardiac or respiratory arrest,  Approximate
A Company of the state of the s	
A Company of the state of the s	resulting in death)  Due to (or as a consequence of):
A Company of the state of the s	Sequentially list conditions, b. endstage Unonce ab Strutive Muzy distance & yes
5 by 5 that initiated events	to If any, leading to immediate Due to (or as a consequence or):    cause. Enter Underlying   Cause (Disease or injury)
Due to (or as a consequence of):	that initiated events ' c. resulting in death) Last Due to (or as a consequence of):
Cause (Disease or injury that initiated events resulting in death) Last  Cause (Disease or injury that initiated events resulting in death) Last  Cause (Disease or injury that initiated events resulting in death) Last  Cause (Disease or injury that initiated events resulting in death) Last  Cause (Disease or injury that initiated events resulting in death) Last  Cause (Disease or injury that initiated events resulting in death) Last  Cause (Disease or injury that initiated events resulting in death) Last  Cause (Disease or injury that initiated events resulting in death) Last  Cause (Disease or injury that initiated events resulting in death) Last	
ifficat of a sa phy as the same of the sam	
IFEMALE: 23d. Date of delivery   23d. Date of delive	23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy
n the past 12 months?   The death   S   Other (specify)   Month   Day Year	
9 □ Unknown	in the past 12 months?  4 Pregnant at time of death 5 Other (specify)
9 Unknown 9 Unknown 9 Unknown 9 Unknown 9 Unknown 9 Unknown	in the past 12 mooks?  1
9 Unknown  9 Unknown  Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  1 Yes 2 No 3 Probably 4 Unknown  1 Yes 2 No 3 Probably 4 Unknown	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death?
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death?  1 Yes 2 70 3 Probably 4 Unknown	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death?
autopsy prior to completion of cause of performed?   1	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death?
## Second autopsy performed? performed? 1□ Yes 2□ No	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death?  1
autopsy performed?   To yes 2 No   To yes 2	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death?  1
autopsy performed?   To yes 2 No   To yes 2	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death?  1
autopsy performed?   To yes 2 No   To yes 2	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death?  1
autopsy performed?   1   Yes 2   No   No   No   No   No   No   No	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death?  1
autopsy performed?   1   Yes 2   No   No   No   No   No   No   No	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.    23e. Did tobacco use contribute to the cause of death?
autopsy performed?   The state of the state	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death?  1
autopsy performed?   The statural   Statural	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death?  1
autopsy performed?   The state of the state	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.    23e. Did tobacco use contribute to the cause of death?

		•	For State Registrar	e of Maryland / D	epartment of H Certificate of L	lealth a Death	and Me		erre 0 0 5	14083
			Decedent's Name (First, Middle, Last)				2	. Date of Death		3. Time of Death
	Physicia /Medic		RONALD	W.	LEU.	115.	Su	APRIL :	Day Year 2005	
	Examin		4a. Facility Name (If not institution, give street and		4b. City, Town, or		of Death STOWN	,	4c. County of De	ath IMORE
			5. Social Security Number 6. Sex	7. Age (In yrs. last birt.		If Under		Date of Birth		
	Funeral Director		216-34-9578 1XM 2C		Yrs. Months Days	Hours	Min.	(Month, Day, ) Sept. 3	(ear) 1937 Ms	irthplace (State or Foreign Country)  ryland
	pu .		Usual Residence of Decedent  10a, State 10b, County	10c. City, Town	or Location					10d. Inside City Limits
	Aaryla f show	ō	Md. Balto.		erstown					1 ☐ Yes 2 🛣 No
	the N	Director	10e. Street and Number		10f. Zip Code			109	g. Citizen of What (	Country?
	23a ol		321 High Falo	con Rd.	2:	1136			U.S.A.	
	tems	Funeral	Arm	Decedent Ever in U.S. ed Forces?	13. Was Decedent of H If Yes, specify Cuba	ispanic Or ın, Mexica	igin? (Speci n, Puerto Ri	fy Yes or No- can, etc.)	14. Race - An Black, Wh	nerican Indian, nite, etc.
36	hours after death with the Maryland turel', or Items 23a or 28a-f show al Examilier inst by mullied at	by Fi	If Ye	Yes 2.1 <sup>®</sup> No s, Give ∵or Dates:	1 ☐ Yes 2 No	Specify:	:		Specify: W	hite
215-0036	72 hou	ted	15. Decedent's Education (Specify only highest grade comple	16a.	Decedent's Usual Occup- (Give kind of work done of		et of working	16	6b. Kind of Busines	s/Industry
2	ithin 7	Completed	Elementary/Secondary (0-12) Colle	ege (1-4or 5+)	life. DO NOT use retired	1)			Cooi-1 C	
121	filed within 72 Hygiene. other than "natent, Ine Medic.		12 3	3	Systems (			First, Middle, Ma		ecurity Adm.
Maryland		To Be	Russell J. Lewis	5					Johnson	
ary	shou and M a mar	-	19a. Informant's Name/Relationship (Type, Prin		. Mailing Address (Street					
Σ,	and 2 ealth m 27 I		Janet L. Lewis - Wit		21 High Falo	on R				
altimore,	iges 1 at of H if itel	j	20a. Method of Disposition 1 ☐Burial 2 ☐Cremation 3 ☐Removal	cemeter	Disposition (Name of y, crematory or other place	(e)	Dat		oc. Location - City	
Ħ	artmer ortant injury		* 4 □ Donation 5 □ Other (Specify)  21. Signature → Foreral ervice Licensee	ALL D	22. Name and Addres		Tender to the second	20, 2005	Reister	
Ba	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 Ia marked any injury or other traumatic ev <u>once</u> .		16/5/la	the	Eckhard	+ Fin	nerel	Chapel,	P.A.	21117
П	4		23a. Part1. Enter the disease, or complications shock, or heart failure. List only one cause	that caused the death. Do no each line.	not enter the mode of dyin	g, such as	cardiac or r	espiratory arres	Owings M	Interval Between
1	Physician		Immediate Cause (Final disease or condition	HEROSCIERO	TIC CARDI	0 42	CULAR	DISE	EAJE	Onset and Death
	/Medical Examiner			ue to (or as a consequence of					*	
Ļ		e		ue to (or as a consequence of	of):					
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events							Manager of the second s
Ö,	e exec ian an urial-tr			e to (or as a consequence of	of):					
58760,	icate be executed physician and s the burial-transit	dical	d			_				
_				s, outcome of pregnancy					23d. Date of d	elivery
P.O. Box	death e atte	Physician/M	in the past 12 months?	Live birth 2 Fetal death	3 ☐Ectopic pregnancy 5 ☐ Other (specify)				Month	Day Year
o.	res that the de signed by the a be detached f	Phys	9 Unknown	Unknown				oo Didaah		
Ŝ	The taw requires that the death certif ate has been signed by the attending page 2 should be detached for use as	by	Part II. Other significant conditions contributing	g to death but not resulting in	i the underlying cause give	en in Part i	l.			to the cause of death?  Probably 4 Anknown
Records,	w require been sig should t	Completed						24a. Was an		* * *
Re	The taw cate has page 2:	omo						autopsy performe	death	
<u>ra</u>		Be C	25. Was case referred to medical			26. Place	e of Death (	1 ☐ Yes 20 Check only one,	No 1 Y	55 20210
<u></u>	Physician: r this certifica ral director, I	To	examiner? 1 Yes 2 No Hospital:	1 Inpatient 2 ER/Ou	tpatient 3 DOA Oth	4 🗆 N			ce 6 □Other (Sp	pecify)
o U C	ding Phys	ilon:	1 Natural 5 Pending		Time of 28c. Injury Work	yat k? Yes 2 □		d. Describe how	injury occurred	
Division of Vital	l or Attendater death Director:	flcat	Z Accident investigation 3 Suicide 6 Could not be determined 28e.	Place of Injury - At home, fa		103 2				Rural Route Number,
6	s after s after al Dire	Certification:	4 Homicide	building, etc. (Specify)				City or Town,	State)	
	dospit t hour unera		29a. Certifier (Check only 2 Medical Examiner: On	To the best of my knowledge the basis of examination and	o, death occurred at the tin	ne, date ar pinion, dea	nd place, an	d due to the cau at the time, dat	se(s) and manner e and place, and d	as stated. ue to the cause(s)
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Medical		manner stated.	29c. Licens				d. Date signed (Mo	
1	F3F77		· Midned Ko	Phy MD	DY	349	ſ			
1	50			cause of death (Item 23a) (					,	2, 2005 CMD 21133
1	10		MICHAEL ROTIKE	N 5401 OLD		D /	29MD4	WION	MARY	( AND 21135
	Sta Registi		31. Date filed (MORT), Day, Year)	22. Registrar's Signature	mak)				,	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ( 1 - State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Year Melette R. Levi April 14, 2005 10:30 A. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** P. G. Hospital Cheverly If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min Yearl 1 □ M 2 🗓 F Yrs. Director Wash., D.C. January 25, 45 577-84-6840 Usual Residence of Decedent the Maryland 10b. Count 10c. City. Town or Location 10a State 10d. Inside City Limits 28e-f shov Examiner must be notified at Landover 1K Yes 2 □ No MD P.G. Directo 10g. Citizen of What Country? U.S.A. 10e. Street and Number 10f. Zip Code 2 should be filed within 72 hours after death with I and Mental Hygiene. Is marked othar than "naturel", or Itams 23a or? 6706 W. Forest Rd. Apt. #101 20785 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 1 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced Black traumatic avant, It's Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Dccupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) 12 Certified Nursing Assistant Health Care 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Delores Rosetta Childress Clarence Levi. Jr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 s ment of Health an Department of Health a Important: If itam 27 is any injury or othar tra Once. Delores Levi - Mother 6706 W. Forest Rd. Apt. #101 Landover, MD 20785 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Apr. 21, 2005 \*4 ☐ Donation 5 ☐ Other (Specify) Ft. Lincoln Cemetery Brentwood, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Ft. Lincoln Funeral Home elliane 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Enysician** latera disease or condition resulting in death) /Medical Due to (or as a consequen **Examiner** Sequentially list conditions. Due to (or as a consequence of) Examiner Tany leading to in medicause. Enter Underlying Cause (Disease or injury The law requires that the death certificate be executed use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): -Ax てOM. をしかといいと Division of Vital Records, P.O. Box 68760, physician Physician/Medical IF FEMALE If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown þ Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably Unknown Be Completed page 2 should septic 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an venous throwhose Deep 2 □ No 1 ☐ Yes 1 Yes 2 No Hospital or Attanding Physician: funeral director 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Inpatient 2 □ ER/Outpatient 3 □ DOA Certification: To this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation after death 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 🕊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

within 24 ho To tha Fund completely 1

State Registrar 29b. Signature and title of certifier

VILLAM MG Hoc . Registrar's Signature

30. Name and address of erso ocompleted cause of death (Item 23a) (Type, Print)

and manner stated.

DHMH 17 Rev 1/200

29d. Date signed (Month, Day, Year) 14/05

CHEVERLY, MD 20785

HOSPITAL DR

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death **Physician** Evelyn 7:20 AM 2005 May Landgraf /Medical 4c. County of Death Boltimore 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Rose 65Pital dal nore anklin 39 If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Days Hours Min 1□ M 2□ F **Director** 216-12-9057 Nov.12,1923 Maryland Usual Residence of Decedent 10a, State 10c. City. Town or Location 10b. County 10d. Inside City Limits 28e-f show other traumatic avent. The Medical Examiner must be notilised at Completed by Funeral Director 1 Yes 2 No Rosedale Baltimore MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 21237 1018 Chesaco Avenue Items 23a 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ▼ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married ö 1 ☐ Yes 2 X No Specify: Specify: 3 XWidowed 4 □ Divorced White \*natural', 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. snt: If itam 27 Is marked other than ' Elementary/Secondary (0-12) College (1-4or 5+) 8 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Florence Nix Clarence Samuel Avers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. George S. Landgraf- Son 8107 Sumter Avenue Rosedale. Maryland 21237 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) ö Department of importent: If any injury or once. 4/28/05 Crownsville Veteran Crownsville, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Heather Cain Leonard J. Ruck, Inc. 5305 Harford Road Baltimore, Maryland 21214 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician 01 disease or condition resulting in death) /Medical **Examiner** obst UN9 DISEASE Chron Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Physician/Medical Examiner the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 1 Live birth 2 Fetal death in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) P.O. 9□ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ of Vital Records. 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an funeral director, page 2: autopsy performed? res 2 2 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 2 ER/Outpatient 3 DOA 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident investigation

Hospitel or Attanding Physician: The law requires that the death certificate be executed Division after death. within 24 hours a To the Funaral C

> State Registrar

DRMH 17 Rev 1/200

filled in by

completely

0

Medical

31. Date filed (Month, Day, Year) APR 2 6 2005

3 Suicide

29a Certifier

4 Homicide

29b. Signature and title

6 Could not be determined

30. Name Ind address of person who completed cause of death (Item 23a) (Type, Print) ornie 9000 Franklin Square Prive Boltimore

and manner stated

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

12 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

10059793

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

05-02803 Lori RJD

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

L	oucks		. For	State of M	larylan						ental Hy		enna.	11.000
			State Registrar			Ce	rtificate	of D	eath			Reg. No.	000	14086
	Physicia		Decedent's Name (First, Middle	LORI	L.	LOUG	CKS			1	2. Date of De Month April		2005 Year	3. Time of Death 2012P. M
	/Medic Examin		4a. Facility Name (If not institution	-	r)			Town, or Lo	ocation of	f Death			County of Dea	
			6501 N. Charles 5. Social Security Number		ge /In vrs	last birthday)	Tows		If Under 2	24 Hrs.	8 Date of Bir		ltimore	
	Funeral Director		585-17-7735	1□M <b>¾(</b> )XF	45	Yrs.	Months		Hours	Min.	8. Date of Bir (Month, Da 03-01-	1960	SOL	rthplace (State or Foreign Country) JTH DAKOTA
	/land		Usual Residence of Decedent  10a. State 10b. County		10c. Cit	y, Town or Lo	ocation							10d. Inside City Limits
	e Mary Sa-f ah Illied	ctor	VERMONT SHE	ELBURNE				SHEL	BURN	IE				1 □ Yes 2 <b>X</b> \\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\
	within 72 hours atter death with the Maryland ene. than "natural", or itams 23a or 28a-i ahow ta M. Jical Exsciller must be notilled at	by Funeral Director	10e. Street and Number 1141 FALLS	S ROAD			10f. Zip	0548	32			10g. Cit	U.S.	
	er deat	uner	11. Marital Status	12. Was Deceden	:?	.S. 13.	Was Deced If Yes, spec	ent of Hisp ify Cuban,	anic Orig Mexican,	in? (Spec , Puerto R	city Yes or No lican, etc.)	D-	14. Race - Am Black, Wh	
036	al', or	by F	1 ☐ Never Married   ★★ Marri 3 ☐ Widowed 4 ☐ Divorced	It Vac (Fiva	197 198	8	1□Yes 2	<b>XX</b> 100	Specify:			Į.	Specify:	WHITE
5-0	"natur	leted		t's Education st grade completed)		(Give	dent's Usua kind of wor DO NOT us	k done dur	on ring most	of workin	g	16b. K	ind of Busines	s/Industry
21215-0036	d withingjene.	Completed	Elementary/Secondary (0-12)	College (1-4or	r 5+)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		ORNEY	′				LAW	
Maryland	permit. Pages 1 and 2 should be tiled within 72 hours atter death with the Marylan Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-1 ahow appring to other traumatic avant, It a Michael Exertice must be notified at once.	To Be (	17. Father's Name (First, Middle,	LEE GOO	)D			11		r's Name RDIS	(First, Middle BORT		Sumame)	
Mary	d 2 shouth and N is ma		19a. Informant's Name/Relations		ID )		-				Route Numb		NT OF	Zip Code)
	as 1 an of Heal of Heal itam 2 r othar		20a. Method of Disposition		20b. F	Place of Disponentery, cre	osition (Nam	ne of	1	Da	ate	20c. L	ocation - City o	r Town, State
Baltimore,	t. Pagritment rtant: I		1 ☐ Burial XX Cremation '4 ☐ Donation 5 ☐ Other (S	ipecify)	HI	LLTOP			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		6-2005	10		RYLAND,21204
Ba	permi Depa Impo any ir		21. Signature of Funeral Service	Licensee			2. Name and RUCK T				HOME,	INC.		YORK ROAD N,MD.21204
	201		23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final	complications that cause only one cause on each	ed the deat line.	h. Do not en	ter the mode	e of dying,	such as o	cardiac or	respiratory a	arrest,		Approximate Interval Between Onset and Death
7	Pnysician /Medical		disease or condition resulting in death)	a. Due to (or a	is a conseq	uence of .								-
	Examiner	70	Sequentially list conditions, if any, leading to immediate	b. Due to (or a	e a consea	mence of).								
	cuted nd ransit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	c	.0 4 0011504	201100 017.								
8760,	cate be executed physician and the burial-transit	ical Ex	resulting in death) Last	Due to (or a	is a conseq	uence of):	-							
9	ifficate g phys as the			d			-241	-					-	
Вох	eath certific attending p I for use as 1	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcom	2 Feta	Ideath 3	⊒Ectopic pre						23d. Date of do	elivery Day Year
P.0.	the de by the a ached f	hysic	1 ☐ Yes 2 ☐ No 9	4⊡Pregnant 9⊡ Unknown	at time of d	leath 5	Other (spe	ecify)						
	law requires that the death certific as been signed by the attending p 2 should be detached for use as I	by	Part II. Other significant conditi	ons contributing to death	but not res	ulting in the s	underlying ca	ause given	in Part I.			tobacco (		to the cause of death?  Probably 4  Unknown
Records,	e law require has been si je 2 should t	Completed									24a. Was		24b. Were a	autopsy findings available completion of cause of
al R	The ate h page										perfe	ormed?	death?	1
Vital	Physician: Th this certificate ral director, pag	o Be	25. Was case referred to medica examiner?  1 XYes 2 No	Hospital:	tient 2	ER/Outpatie	nt 3□ D0	Othor			(Check only		6 ☐Other (Sp	ecify)
n of	ding Phys h. After this funeral di	on: T	27. Manner of Death 1 □Natural 5 □ Pendir	28a. Date of In		28b. Time of		8c. Injury a Work?	ıt	2	8d. Describe			1001
Division	Attanding r death. sctor: After by the fune	Certification;	2 Accident investi	not be 28e. Place of I	njury - At h	ome, farm, st	treet, factory	1 🗌 Ye	s 2 N	-	St. Location	CC W (Street ar	nd Number or F	Rural Route Number,
ă	ital or rs after rs after ral Direction the	Certi	4 Homicide	building,	etc. (Special	Dital	S			G	City or To	wn, State	shoppa	TOMO 21204
	To the Hospital or Attanding within 24 hours after death. To tha Funaral Director: After completely filled in by the fune.	edical	29a. Certifier 1 Certifyin (Check only 2 Medical one)	ng Physician: To the bea Examiner: On the basis and manner	of examina	wledge, dea ation and/or is	th occurred anvestigation,	at the time, in my opin	, date and nion, deatl	d place, a th occurre	nd due to the d at the time,	cause(s , date an	) and manner a d place, and du	as stated. ue to the cause(s)
	To the to within 2 To the complet	Me	29b. Signature and time of certifil	MA			290	. License r	number				te signed (Mor	
)	NX		Alle	my 10.				OCME				Apri	1 22,	2005
/	ax,		30. Name and address of person	who completed cause of			1	L11 P	enn S	Stree	et Bai	ltimo	ore, Ma	ryland 21201
	Sta Registi		31. Date filed (Month, Day, Year	R 2 6 2005 Regis	sterr's Signa	ature J.	Apa							

	-	State of Maryland / Departs State of Maryland / Departs Cert	rtment of Health and M Fificate of Death	lental Hygie	6005	14087
		Decedent's Name (First, Middle, Last)		2. Date of Death	_	3. Time of Death
Physici /Medic		Frank S. Lipira, Sr.		April	<sup>Day</sup> 2005	7:00 A M
Examir		4a. Facility Name (If not institution, give street and number) 2071 Druid Park Drive	4b. City, Town, or Location of Death Baltimore		4c. County of De	
Funeral Director		5. Social Security Number  219-42-2194  6. Sex 1 M 2 F 62  Yrs.	If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, You Aug. 16,	9. B	irthplace (State or Foreign country) aryland
aryland show	2	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Loc	ation			10d. Inside City Limits 1 1 Yes 2 □ No
the M	Funeral Director	MD N/A Baltimore	10f. Zip Code	100	. Citizen of What (	
with with	ä	2071 Druid Park Drive	21211	US		Southly.
Jeath ms 23	era	11 Marital Status 12. Was Decedent Ever in U.S. 13. W	/as Decedent of Hispanic Origin? (Sp Yes, specify Cuban, Mexican, Puerto		14. Race - An	nerican Indian,
urs after o	by Fun	1 □ Never Married 2 □ X Married 1 □ Yes 2 X No	Yes, specify Cuban, Mexican, Puerto  ☐ Yes 2 ☑ No Specify:	Rican, etc.)	Specify: W	
Defiliniore, Ivial yiello 2 12 13-0030  bermit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene.  mportant: If item 27 is marked other than "natural", or itams 23e or 28e-f show myniury or other traumatic event, the Mudical Examinar is until to notified at 2008.	Completed	(Specify only highest grade completed) (Give k	ent's Usual Occupation kind of work done during most of work O NOT use retired)	ing 16	b. Kind of Busines	ss/Industry
d with giene.	шо	Elementary/Secondary (0-12) College (1-4or 5+) Ground	dskeeper	Д	thletics	
yicano 2 12 buld ba filad with Mental Hygiene arkad other tha atic event, ins.	Be C	17. Father's Name (First, Middle, Last)		e (First, Middle, Ma		
should be filed and Mental Hygi marked other matic event, I	To	Frank S. Lipira		Gloriosio		
Michael d 2 d 2 d 2 d 2 d 2 d 2 d 2 d 2 d 2 d			g Address (Street and Number or Rur Druid Park Drive;			
of He		20a. Method of Disposition 1 □XBurial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition cemetery, crem	sition (Name of atory or other place)	Date 20	c. Location - City	or Town, State
Pages ment of I ant: If its ury or o		*4 Donation Content (Specify) Woodlawn	Cemetery 4/25	/05 Ba	ltimore,	
Dallinore, permit. Pages 1 an Department of Heal Important: If item 2 any injury or other			Name and Address of Facility  CK Towson Funeral	Home	1050 Yor Towson,	k Road MD 21204
Physician / Medical Examiner supplies the private of the physicien and physicien and supplies the private of th	dical Examiner	23a. Part1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  C		Leukei		Onset and Death 3 years
the death certify the attending ched for use a	Completed by Physician/Mec		Ectopic pregnancy Other (specify)		23d. Date of Month	delivery Day Year
uires that signad b	d by Pi	Part II Other significant conditions contributing to death but not resulting in the un Pancy to new 1d	nderlying cause given in Part I.	23e. Did toba 1 ☐ Yes	_/	e to the cause of death?  Probably 4 □Unknown
he law requires the has been signate age 2 should be company.	nplete	Coronary Antery Disease		24a. Was an autopsy performe	prior	autopsy findings available completion of cause of
	S	Cirrhosis, Congestive ne	art tailure	1 ☐ Yes 2	No 1□Y	
VILCII sician: 1 certificat rector, pa	Be	25. Was case referred to medical examiner?  Hospital:	Other	th (Check only one)		· · · · · · · · · · · · · · · · · · ·
ding Physician: The Ind. h. After this certificate ha funeral director, page	ion: To	1 Yes 2 No Tuspital 1 Inpatient 2 ER/Outpatien  27. Manne of Death 1 Natural 5 Pending (Month, Day Year) Injury	1 3 DOA 4 INdishig II	28d. Describe how		респу)
or Attenorter deat	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, stribuilding, etc. (Specify)		28f. Location (Stre City or Town,		Rural Route Number,
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director.	edical Ce	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death of the basis of examination and/or in and manner stated.				
To the within To the comple	Mec	29b. Signature and title of certifier	29c. License number		d. Date signed (M	
1		· ( lalus & & Molles M	1) 136356	o A	pru 22	, 2005
5			D D36356 N. Belvedere M	tve, Su	rtezz B	MD 21215
S <sup>1</sup> Regis	tate trar	31. Date filed (Month, Day, Year) APR 2 6 2005	post	•		

	·	1 - For State Registrar	State of Ma	aryland /		artment of H		Mental H	ygier Reg. F	200	15	14088
9 .		1. Decedent's Name (First, Middle, Las	st)					2. Date of E	eath		Vana	3. Time of Death
Physic /Medi		Maria-Waid McKr	night Lechr	ner				April		oay • 200	Year 5	7:00A M
Exami		4a. Facility Name (If not institution, give	e street and number)			4b. City, Town, or	Location of Dea	ith	4	4c. County	of Death	
		Holy Cross Hosp				Silver	Spring			Montg		
Funeral		5. Social Security Number 6. S	ex 7. Age □M 2【X】F	e (In yrs. last b	irthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min	(Month, I	irth Day, Yea	ar)	9. Birthr	place (State or Foreign ntry)
Director		368-20-5973 Usual Residence of Decedent		81	115.			April	3,	1924	New	York
tand		10a. State 10b. County		10c. City, To	wn or Lo	cation						10d. Inside City Limits
Mary Fed	to	Maryland Montgom	erv	Potom	ac							1 ☐ Yes 2 📉 No
r 28e	Funeral Directo	10e. Street and Number	CLY	1000111	ac	10f. Zip Code			10g. (	Citizen of \	What Cour	ntry?
h with	<u>=</u>	11722 Devilwood D	rive			20854			Un	ited	State	20
deatl	ner	11, Marital Status	12. Was Decedent E Armed Forces?	Ever in U.S.	13.	Was Decedent of H If Yes, specify Cuba	ispanic Origin? (	Specify Yes or N		14. Rac	e - Americ	can Indian,
ife, INTALYIGHTO ZIZID-UUDO s 1 and 2 should be filed within 72 hours after death with the Maryland of Heelth and Mental Hygiene, Item 27 is marked other than "natural", or items 23s or 28e-1 show other traumatic event, the Medical Eventrating must be notified at	þ	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 Yes 2 N If Yes, Give Year or Dates:	40		1 ☐ Yes 2 🖾 No	Specify:	no rican, etc.)		Specify	ck, White, v: Whi	
2 ho	ted	15. Decedent's Ed	ducation	16	a. Dece	dent's Usual Occup	ation		16b.	Kind of B		
thin 7	Completed	(Specify only highest gra	College (1-4or 5	i+)	life.	kind of work done o DO NOT use retired	during most of wo	orking				
er th	000		4			eacher			E]	Lemen	tary	School
all Hy	Be (	17. Father's Name (First, Middle, Last)	)				18. Mother's Na	ame (First, Midd	le, Maid	en Suman	ne)	
yland buld be filt Mental Hy arkad oth attc even	P	Waid Heenan McKn	ight				Marie	Schlei	cher	<u>:</u>		
Mar d 2 sho th and 7 is my traume		19a. Informant's Name/Relationship (	Type, Print)	19	b. Mailir	ng Address (Street a	and Number or F	Rural Route Num	ber, City	y or Town,	State, Zip	Code)
and and m 27 m 27 ner tr		Thomas Fletcher L	echner/Hus	sband 1	1722	Devilwo	od Drive	Potom	ac,	Mary	land	20854
of H		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐	Removal from State	cemet	erv. cres	sition (Name of natory or other place	e) Apr	il 19,	20c.	Location -	City or To	own, State
Daltimore, IM permit. Pages 1 and 2 Department of Heelth a Importent: If Item 27 is eny injury or other tra once.		'4 □ Donation 5 □ Other (Specif	y)	Montg Crema	tori	um. Inc.	200	15	Вє	thes	da, M	Maryland
Dall permit Depart Import Import eny inj		21. Signature of For I Service Lice	<b>1</b> 00		R.C	2. Name and Addres	ss of Facility Ro	bert A.	Pun	phre	y Fur	neral Home,
u 4053a		Muile.		M00803	Be	thesda. N	Maryland	20814	-350	)1	LSCOT	neral Home, nsin Avenu
		23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused one cause on each lin	the death. Do	not ent	er the mode of dyin	g, such as cardia	ac or respiratory	arrest,			Approximate Interval Between
Physician		Immediate Cause (Final disease or condition	Aspira	tion P	neum	onia						Onset and Death 4 Days
/Medical Examiner		resulting in death)	Due to (or as	a consequence	e of):							
Examine		Sequentially list conditions,	b									
/ gr gr	ine	if any, leading to immediate cause. Enter Underlying	Due to (or as a	a consequence	e of):							
be executed ician and burial-transit	Examiner	that initiated events resulting in death) Last	c Due to (or as a	a consequence	e of):							
/ oU, te be ey ysician e buria	calE		200 (0 (0) 23 (	a sonsoqueno	3 31).							
oor incate p phys	edic		_ d		-							
Theconds, P.O. box os/ou,  The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physiclan/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12-months?	23c. If yes, outcome of 1 Live birth		th 3[	Ectopic pregnancy					te of delive	ery Day Year
the dea	/sic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregnant at 9 ☐ Unknown	time of death	5	Other (specify)				1010	****	Duy You.
d by	Phy	Part II. Other significant conditions of	contributing to death by	ut not reculting	in the u	ndoching course and	on in Bod I	23a Dic	Ltobaco	o use cont	ribute to t	he cause of death?
resth signe	by	Cerebrovascular		ut not resulting	ព្រះព្រមប	nderlying cause givi	en in Pait I.					pably 4 Unknown
law requires that seem signed as been signed to seem signed to see	ted								, 103	2 02140		- Johnson
has b	Completed	Congestive Heart	Failure					24a. We	opsy		prior to co	psy findings available mpletion of cause of
The The cete	Cor							1 ☐ Yes	formed?	No	death?	2 □ No
Of VICAL INE Property of the law tribis certificate has rail director, page 2	Be	25. Was case referred to medical examiner?	Magnital			0.1		eath (Check only				
Physic ruthis or rail directions	T <sub>0</sub>	1 ☐ Yes 2 🛣 No		nt 2 ER/C		t 3 DOA	er: 4 Nursing					y)
VISION C Attending P or death. octor: Alter t by the funera	ation	27. Manner of Death  1 Anatural 5 Pending 2 Accident investigation		y Year) 286	. Time of Injury	Worl	/ at k? Yes 2 □ No	28d. Describe	now in	qu <b>ry</b> occur	red	
To the Hospital or Attending within 24 hours after death. To the Funeral Director: Alter completely filled in by the funeral	Certification:	3 Suicide 6 Could not b 4 Homicide determined	e 28e. Place of Injubuilding, etc	ury - At home, c. (Specify)	farm, str	eet, factory, office		28f. Location City or T			er or Rura	al Route Number,
• Hospl • 24 hour • Funer letely fill	edical	29a. Certifier  (Check only one)  Check only 2 ☐ Medical Exer	nysicien: To the best of miner: On the basis of and manner sta	examination a	ge, deat and/or in	n occurred at the tin vestigation, in my o	ne, date and place pinion, death occ	e, and due to th curred at the time	e cause e, date a	(s) and ma and place,	anner as si and due to	tated. the cause(s)
To th Withir To th	Me	29b. Signature and title of certifier	60	0 11	10	29c. License	e number		29d. [	Date signe	d (Month,	Day, Year)
		> Ksheu	na ha	9 191	0)	D608	326		Ar	ril	16. 2	2005
20		30. Name and address of person who	completed cause of de	eath (Item 23a	) (Type,				41		-0, 2	.005
<i>-</i>		Kshama Garg, M.D	. 1500 Fo	rest G	len	Road, Sil	ver Spr	ing, Man	vla	nd 2	20910	
St	ate	31. Date filed (Month, Day, Year)	32. Registra	ar's Signature			_					
Regist	rar	AP	R 2 6 2005	Le.		W So	~					
URMH 17 Rev 1/2	2001		0 0000	Julie Constitution of the	200	C. James						
				OR	IGINA	AL						

DHMH 17 Rev 1/2001

			State Registrar	ite of Maryland / I	Department Certificate		F	Reg. No. UUD	14089
	Physici /Medio	al	1. Decedent's Name (First, Middle, Last) Christine B. Li				2. Date of Dea Month April 1	Day 2005 Year	3. Time of Death 1:30 P M
	Examir Funeral	er	4120 Montpelier Road 5. Social Security Number 6. Sex	7. Age (In yrs. last bi	Rocarthday) If Under	Ckville Year   If Under 24 Hrs. Days   Hours   Min.	8. Date of Birth (Month, Day March 2	4c. County of Death  Montgome  h (, Year)  9. Birth	
	Director Mod-		201-30-1233	75	Yrs.	Seyo Heart	March 2	7,1930 Ch	Ina 10d. Inside City Limits
	d within 72 hours after death with the Maryland Jene. r than "natural; or items 23a or 28a-f show the Medical Exacting artmast be redified at	rai Director	Maryland Montgomery  10e. Street and Number  4120 Montpelier Road	Rockv	10f. Zip	0853	U	10g. Citizen of What Co	es
9000	hours after de turai', or item	ed by Funerai	1 □ Never Married 2 ☑ Married 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	as Decedent Ever in U.S. med Forces? ] Yes 2 M No Yes, Give ar or Dates:	If Yes, spec		ecify Yes or No-	Specify: Asi	a, etc. .an
Maryland 21215-0036	d within giene. r than "	Completed	15. Decedent's Education (Specify only highest grade com Elementary/Secondary (0-12)  17. Father's Name (First, Middle, Last)	oleted) illege (1-4or 5+)	Decedent's Usua (Give kind of worn life. DO NOT us ietician	k done during most of work e retired)		Bio-Techno	
laryland	should be nd Menta marked	To Be	Lam S. Lee  19a. Informant's Name/Relationship (Type, P.	int) 19	b. Mailing Address	Mary Kuc	)	Maiden Sumame) or, City or Town, State, 2	Tip Code)
Baltimore, M	es 1 an of Heel f item 2 r other		Thomas Li / Husband  20a. Method of Disposition  1 X Burial 2 Cremation 3 Remov  4 Donation 5 Other (Specify)	20b. Place of Gate	20 Montpel of Disposition (Name of Heaver etery	ier Road, Roc e of her place) April 200	Pata 22,	Maryland 20 20c. Location - City or Silver Spring	Town, State
Balti	permit. Pag Department Important: i any injury o		21. Signature of Fungral Sérvice Livensee	M01353	Rockvil Rockvil	Address of Facility Rollie, Inc., 30 le, Maryland	0 West 20850-	Montgomery 2805	Avenue
	Physician /Medical		23a. Part1. Enter the disease, or complication shock, or heart failure. List only one caulimmediate Cause (Final disease or condition resulting in death)	Striat caused in the death. Do see on each line.  METASTAT  Due to (or as a consequence  EARLY ST  Due to (or as a consequence					Approximate Interval Between Onset and Death  MONTH
8760,	sate be executed whysician and the burial-transit	icai Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c	EARLY ST Due to (or as a consequence		BREAST O	ANCE	R	43 MONTH
.O. Box 6	The law requires that the death certifica te has been signed by the attending phoaps 2 should be detached for use as the	Physiclan/Medical	in the past 12 months?	yes, outcome of pregnancy □Live birth 2 □ Fetal deatl □Pregnant at time of death □Unknown	h 3 Ectopic pre 5 Other (spe			23d. Date of deli Month	very Day Year
ecords, P	w requires that been signed b should be deta	by	Part II. Other significant conditions contribut	ing to death but not resulting	in the underlying ca	use given in Part I.	23e. Did to	obacco use contribute to	
$\mathbf{\alpha}$		e Completed	25. Was case referred to medical					prior to death? 2 No 1 Yes	topsy findings available completion of cause of
sion of Vital	ding Phys  After this funeral di	To B	examiner?  1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending investigation 2 Accident	a. Date of Injury 28b.		26. Place of Deat  Other: 4 \sum Nursing Ho  3c. Injury at Work? 1 \sum Yes 2 \sum No	ome 5 Hesio	ne) dence 6 ⊡Other <i>(Spec</i> low injury occurred	cify)
Division	- e - c	al Certification;	4 Homicide	Place of Injury - At home, f building, etc. (Specify)     To the best of my knowledge			City or Ton		
	To the Hospital or within 24 hours after To the Funeral Dir completely filled in	Medical	(Check only 2 Medical Examiner: (	on the basis of examination and manner stated.	nd/or investigation,	in my opinion, death occur  License number	red at the time,	date and place, and due 29d. Date signed (Month	to the cause(s)
' _	P			Newuse of death (Item 23a)	(Type, Print) 1650	)39774 ONLEANS	STREE	57 #189 /	BACTIMONS MD 21231
	Sta Regist		31. Date filed (Month, Day, Year)	32. Registrar's Signature	Re A	Carles			

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2005 **Physician** \$134M arvin  $\alpha$ /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore HOSpita SIMAI Year If Under 24 Hrs. 8. Date of Birth Month, Day, Year, Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 M 2 □ F Months Days Hours 241-11-0201 Yrs. Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-1 shov other traumatic event, the Medical Ever, it ar must be notified at Baltimore 1 Yes 2 No Completed by Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō ruvelann items 23a 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cupan, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ŏ 1 ☐ Yes 2 ☑ No Specify: BIACK 3 Widowed 4 Divorced "natural" 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry and Mental Hygiene. College (1-4or 5+) Farmel Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) To Be lalle 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Num e) City or Town, State, Zip Code) 21229 itam 27 200towlkes (Niece 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State jo == 1 

✓ Burial 2 

☐ Cremation 3 

☐ Removal from State ō permit. Page Department ( Important: It any injury or once. -28-05 Junes Chapel Bapt. Ch. Cem. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Mucha C Greene Funeral Ra KandallStown 23a. Part1. Enter the fisease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate
Interval Between
Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** hrombosis MIS /Medical Due to (or as a consequence of): Examiner ardiovascular dispusi erotic 2510 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) Box 68760, use as the IF FEMALE: If yes, outcome of pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4☐Pregnant at time of death 5 Other (specify) P.O. detached 9□ Unknown ģ signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an page 2 s autopsy 2 No 1 ☐ Yes director, 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 🔲 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 2 V ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending death. 2 Accident investigation Director: 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 Homicide within 24 hours a To the Funeral I pellil 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) completely 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) CM 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DINAI laria

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

APR 2 6 2005

2. Registrar's Signature

			For State Registrar	State of	Maryland		artment of H		nd Ment		ene 05	14091
	Physici /Medic		1. Decedent's Name (First, Middle Edward Mart	. ,						oate of Death Month Dril 20	Day 2005 Yea	3. Time of Death
	Examin		4a. Facility Name (If not institution Upper Chesapea	-		r	4b. City, Town, or Bel Air		4c. County of De			
Ē	Funeral Director		5. Social Security Number 020-20-1901	6. Sex 1 M 2 F	7. Age (In yrs. I	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hours	Hrs. 8. 0 Min. Mar	ate of Birth Month, Day,	(year) 9. B	irthplace (State or Foreign Country) .a.s.s.
	aryland show d at	<u>.</u>	Usual Residence of Decedent  10a. State 10b. County		10c. City	, Town or Lo	cation					10d. Inside City Limits
	th the Ma or 28a-f	Funeral Director	Md. Harf	ord			Bel Air	r		10	g. Citizen of What	1   Yes 2   No X
	sath wir	eral D	1410 Gunsto		dont Ever in 111	3 42.1		015	0.70		U.S.A.	and an about
-0020	ours after de ral', or item Examinar	þ	11. Marital Status  1 □ Never Married 2 ☒ Marri 3 □ Widowed 4 □ Divorced	Armed For	2 □ No		Was Decedent of Hi f Yes, specify Cuba 1 ☐ Yes 2⊠ No	ispanic Origin in, Mexican, P Specify:	uerto Ricar	Yes or No- n, etc.)	Black, Wh	
0-6171	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importents if Item 27 is marked other than "netural", or Items 23a or 28a-f show any injury or other treumatic event, the Medical Examinar must be notified at once.	Completed	15. Decedent (Specify only highes Elementary/Secondary (0-12)	's Education it grade completed) College (1-	-4or 5+)	(Give life. i	dent's Usual Occupi kind of work done o DO NOT use retired	ation during most of ()	f working	(	Sb. Kind of Busines Chemical Company	
/lang z	should be filed ind Mental Hygis marked other umatic event, I	To Be Co	17. Father's Name (First, Middle, Salustiano Mar	Last)		Cire	,111001		Name (Firs	st, Middle, Ma	aiden Surname)	
, Mar)	and 2 sho laith and 1 1 27 is ma er treums		19a. Informant's Name/Relationsh Margaret T. Mar				g Address (Street a				City or Town, State	Zip Code)
aitimore	Pages 1 and the notest of the		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 4 ☐ Donation 5 ☐ Other (S)		State	ace of Dispo emetery, crer	sition (Name of natory or other place rematory	e)	Date / 23 / 20	20	Oc. Location - City of Baltimore	
סמונו	permit. Departn Importe any inju		21. Signature of Funeral Service	Licensee	/	22	Name and Address Schimunel	s of Facility Funer	ral Ho	ome of	Bel Air,	Inc.
ľ	Physician		23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition	complications that ca only one cause on ea	aused the death	. Do not ent	er the mode of dyin	g, such as car	rdiac or resp	piratory arres	Le.	Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (c	or as a consequ	ence of):	e ma a	Hee	+	Di	SIGH	Years
	cuted Id ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (c	or as a consequ	ence of):	co Alac	use,	4	, xe X	Custe	Veare
,007	certificate be executed rding physician and use as the burial-transit	Ical Ex	resulting in death) Last	Due to (d	or as a consequ	ence of):			/			
O. Box og	death certific e attending p id for use as	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ So 9 □ Unknown		rth 2 ☐ Fetal ant at time of de	death 3	Ectopic pregnancy Other (specify)				23d. Date of d Month	elivery Day Year
ecords, r.	law requires that the as been signed by th 2 should be detache	by	Part II. Other significant condition	ns contributing to de	ath but not resu	lting in the u	nderlying cause give	en in Part I.		23e. Did toba		to the cause of death?  Probably 4 Unknown
r,	62 53	Completed							_	24a. Was an autopsy performe	prior to	
N II G	Physicien: r this certific ral director,	o Be (	25. Was case referred to medical examiner?	Hospital:	-5		t all DOA Othe	25		eck only one)		
0 10	Phy this ald	<b>-</b>	1 Yes 2 No  27. Manner of Death 1 Stural 5 Pendin 2 Accident investig	28a. Date o		28b. Time of Injury	28c. Injury Work	4   Nursir	28d. (		ce 6 □Other (Sp v injury occurred	ecify)
DIVISION	To the Hospitel or Attending I within 24 hours after death. To the Funerel Director: After completely filled in by the funer	ertification;	3 Suicide 6 Could r 4 Homicide determi	ned 286. Place	of Injury - At hor	me, farm, str	eet, factory, office		281. L	ocation (Stre City or Town,	et and Number or I State)	Rural Route Number,
	e Hospite 124 hours 16 Funere	edical C	29a. Certifier  (Check only one)  Certifyin  2 Medicel I	g Physicien: To the Examiner: On the ba	sis of examinat	vledge, death ion and/or inv	n occurred at the time vestigation, in my op	ne, date and pointion, death of	place, and d occurred at	ue to the cau the time, dat	ise(s) and manner a e and place, and di	as stated. ue to the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier	205			29c. License	number	3	290	d. Date signed (Moi	onth, Day, Year)
4	414		30. Name and address of person	who completed cause	of death (Item	23a) (Type,	Print)	What	rela	Di	no B	AS
· C	Sta Registr		31. Date filed (Nonth, Day, Year) APR 2 6 2005	32. Re	egistrar's Signat	ure	7790	-0-7		. 10	/	- ( / / / / /

0-2829 3.K.S [CHAEL R. M	ΕA	Please Type or Print in Black Indelible Ink. Ensure A  DOWS State of Maryland / Department of Health and N	-	_	ible.	
Physicia	an	1 - StateUnpend Item 23a,27,28a-f per mc 68463a	2. Date of D Month APRTI	Day	Year 0641 A	
/Medic Examin		4a. Facility Name (If not institution, give street and number) 6895 JOHN PICKETT ROAD 4b. City, Town, or Location of Death WOODBINE		4c. Count	ty of Death	-
Funeral Director		5. Social Security Number 217-02-3174 6. Sex 22 7. Age (In yrs. last birthday) 1f Under 1 Year 1f Under 24 Hrs. Months Days Hours Min.	8. Date of E (Month, I July	Birth (Pear) 20 1982	9. Birthplace (State or F Country)  Md	oreign
the Marylar 28a-f show	Director	10a. State Md Carroll 10c. City, Town or Location Woodbine		10g. Citizen of	10d. Inside City I 1 ☐ Yes 2	
re, Maryland 21215-0036  s 1 and 2 should be filed within 72 hours after death with the Maryland Fleath and Mental Hygiene. item 27 is marked other then "natural", or Itams 23s or 28s-f show other treumatic event, the Medical Exeminer must be notilized at	Funeral Di	6895 John Pickett Road Apt A 21797  11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Sp. 1798, specify Cuban, Mexican, Puert	pecify Yes or No Rican, etc.)	USA	ce - American Indian, ack, White, etc.	
Maryland 21215-0036 to 2 should be filed within 72 hours afte the and Mental Hygiene. It is marked other than "netural", or treumatic event, tre Medical Exercitivaments	þ	3 Widowed 4 Divorced Ff Yes, Give Year or Dates:  15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done during most of work done during most of work done)	king	16b. Kind of B	Business/Industry	
nd 212- be filed within tal Hygiene. d other the	Be Completed	.1. 0 11 1/	ne (First, Midd ra Smit	Jiffy He, Maiden Suma		
≥ 5 ± 2 ±	To	19a. Informant's Name/Relationship (Type, Print)  Barbara Barr (mother)  19b. Mailing Address (Street and Number or Ru. 6895 John Pickett Rd.	ral Route Num	nber, City or Towr		
O 85=2		20a. Method of Disposition  1 Dispos		Mt. Ai	* *	
Baltim permit. Pa Departmer Important any injury ance.		21. Signature of Funeral Service Licensee  22. Name and Address of FacilityHai  23. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line.	ville,	Md 2178		
Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)  Narcotic intoxication  Due to (or as a consequence of):			Onset and Dea	ith .
- 6 -	edicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  C.  Due to (or as a consequence of):  d.				
P.O. Box 68760 nat the death certificate be red by the attending physician elached for use as the buri	by Physician/Medical	fF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown   23c. If yes, outcome of pregnancy   1   Live birth 2   Fetaf death   3   Ectopic pregnancy   5   Other (specify)   9   Unknown   5   Other (specify)   5			ate of delivery onth Day Yea	r
		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		1 tobacco use con	tribute to the cause of deat	
Vital Rec itcien: The law certificate has b	Be Completed	25. Was case referred to medical 26. Place of Deal	17 Yes	opsy formed? 2 \( \sum \) No	Were autopsy findings ava prior to completion of caus death? 1 Yes 2 No	ilable e of
on of ding Phys	Certification: To E	examiner?  1 Yes 2 No  Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA  Other: 4 Nursing Holds  1 Natural 1 Natural 2 Note of Injury 1 Note of 1 Note	28d. Describe	how injury occur	ner (Specify) AT SCE rred <b>unk</b> ber och und Route Number 5 <b>John Picke</b>	
Division To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	edical Cer		Woodbi	ne, Mary	1and	
To the within To the comple	Me	29b. Signature and title of certifier  OCME		29d. Date signe	23, 2005	
Sta	te	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  111 Penn Stree  31. Date filed (Month, Day, Year)  32. Registrar's Signature	eet Ba	ltimore,	Maryland 21	201
Registra	ar	APR 2 6 2005 Keen & Jack				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygierie 1 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav **Physician** Apri1 5:45 p. /Medical Yvonne Ann Martin 2005 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Joseph Richey Hospice If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 □ M 2X F Director 59 215-46-9296 Apr. 20, 1946 Maryland Usual Residence of Decedent 10b. County 10c, City, Town or Location 10a. State 10d. Inside City Limits or 28e-f show treumatic event, the Madical Exertiner must be notified at 1 ☐ Yes 2√∑ No Director Baltimore Maryland Dunda1k 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1211 South 48th Street

11. Marital Status

1 Never Married 2 Married

3 Widowed 4 Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: Funerai United States 21222 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. ō 1 ☐ Yes 2 X No Specify: Specify: White Completed by 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) 12 should be filed within 7 h and Mental Hygiene. 7 is marked other then "r Elementary/Secondary (0-12) College (1-4or 5+) Own Home 12 years Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be John P. Gwiazedwski Elizabeth McKenna 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Importent: If item 27 is m eny injury or other treum once. 1211 South 48th Street Dundalk, Maryland 21222 James F. Martin (Husband) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Donation 5 Other (Specify) Gardens of Faith Cem. 4/25/2005 Baltimore, Maryland e of Funeral Service Licensee 21. Sign 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Avenue Dundalk, Maryland, 21222 23a Perrt. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final non-small cell lung cances Metastatic **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to mind a cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death 5 Other (specify) should be detached 9 Unknown 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by AST HMA Chronic 1 ☐ Yes 2 ☐ No 3 No Probably 4 ☐ Unknown disease, 24b. Were autopsy findings available prior to completion of cause of death? Coronay 24a. Was an autopsy performed anema, thrombuaytopenia atherosclarosis 1 Yes 2 XNo 1 TYes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Wither (Specify) hospica 1 ☐ Yes 2 X No Certification; To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident Director 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specily) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours to the Funerel I Excertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. onel 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Maidaroll no Physician D47 105

Registrar DHMH 17 Rev 1/2001

State

30. Name and address of pers a who completed cause East

31. Date filed (Month, Day, Year)

Tager

Baltomne

Street

2001

32. Registra Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Death 1. Decedent's Name (First, Middle, Lest) 3. Time of Death Month Day Year **Physician** APRIL 22 05 IEAN MACMASTER 17-50AM /Medical 4b. City, Town, or Location of Death 4c. County of Deeth 4a Fecility Name (If not institution, give street and number) Examiner Baltimore Genesis Multi-Medical Towson If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Months Days Hours 1□ M 2√ F Yrs 86 Director 218-09-9947 June 7, 1918 Maryland Usuel Residence of Decedent permit. Peges 1 end 2 should be filed within 72 hours efter death with the Merylend Depertment of Heelth and Mentel Hygiene. Important: if item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumetic event, if a Medical Examinal must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 Tyes 2 No Director MD Sparks Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street end Number 21152 USA Funeral 16604 Dubbs Road 12. Was Decedent Ever in U,S. Armed Forces?

1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 🛣 No Specify: Specify: White δ 3 Nidowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) N/A Elementary/Secondery (0-12) 12 Administrative Assistant Airlines 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be E. Grace Gorsuch ဥ Harry V. Miller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 16604 Dubbs Road Sparks, MD 21152 Barbara Franklin/Niece 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State cemetery, crematory or other place) Baltimore Washington 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 26, 2005 Laurel, MD 4 ☐ Donation 5 ☐ Other (Specify) Crematory 21. Signature of Funeral Service 22. Name and Address of Facility Lemmon Funeral Home of Dulaney Valley, Inc. Michael J. Flagle 10 W. Padonia Road Timonium, MD 21093 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in deeth) /Medical DEN EN TIA monto Examiner Physician/Medical Examiner Due to (or as a consequence of): Hospital or Attending Physician: The lew requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury CORONERY ARTERY DISEASE Division of Vital Records, P.O. Box 68760, that initiated events Due to (or as e consequence of): resulting in death) Last 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yea 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? 1L Yas 32No 1 ☐ Yes 2 ☐ No 8 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No this 27. Manner of Deeth 28b. Time of 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred edical Certification: 5 Pending investigetion in 24 hours efter deeth.
the Funeral Director: After 1- Naturel 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide to Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner steted. 29a. Certifier To the Hospi within 24 hou To the Funer completely fil (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Spepte MD DOOS 3150 30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print) 7200 YORN ROAD TOWSON ZIZOL GUPTA ND SHAWNMARA 31. Date filed (Month, Day, Year) 32. Registrer's Signature State Registrar APR 2 6 2005

Baltimore, Maryland 21215-0036

P.O. Box 68760,

Division of Vital Records,

Registrar DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygienen For State Registra Certificate of Death Reg. No. 2. Date of Death 19<sup>Day</sup> 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** APRIL 2005 MAZAN FLORENCE 3:00 P /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Deeth 4b. City. Town, or Location of Death Examiner CHESAPEAKE HOSPICE HOUSE LINTHICUM ANNE ARUNDEL If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6 SAY Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day. **Funeral** Year) Days Hours Min 1 □ M 2 1 X F 83 Yrs 18, 1921 220-03-6994 MD Director Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 X No Funeral Director MD ANNE ARUNDEL GLEN BURNIE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Пета 238 623 MARLBORO ROAD 21061 **IISA** 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural, or Item any injury or other traumatic event, the Medical Control of the traumatic event eve Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: WHITE þ 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be WALTER MONKA STELLA MONKA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1467 AMBERWO D DR. N. ANNAPOLIS, MD 21401 position (Name of ematory or other place) APRIL 325 20c. Location - City or Town, State BONNIE PATRICK / DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Xeurial 2 Cremation 3 F
4 Donation 5 Other (Specify) 3 Removal from State MARYLAND VETERANS
22 name and oddress of Facility 2005 CROWNSVILLE, MD SECOND AVE. S.W. 21. Signature & Frinery Se MO1411 GLEN BURNIE, MD 21061 SINGLETON FUNERAL HOME, Approximate Interval Between Onset and Death Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each ling. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Otre to (or as a con Examiner or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760, the attending physician Completed by Physician/Medical IF FEMALE esn 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No
9 Unknown 23d. Date of delivery 3 Ectopic pregnancy ö Month Year Day 4 Pregnant at time of death 5 Other (specify) P.O. detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. 1 🗌 Yes 2 🗆 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an has page 2 autopsy 1 Yes 2 No funeral director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4  $\square$  Nursing Home 5  $\square$  Residence 6  $\square$ Other (Specify) $\square$ HOSPICE 1 Yes 2 No 1 🗌 Inpatient Certification: To 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 Natural 2 Accident 5 Pending investigation 2 🗌 No death. 1 Tes in by the within 24 hours after deal To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide pelli Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier the 29b. Signature and title of certifie 29d. Date signed (Month, Dey, Year) 29c. License number 0 APRIL enly completed cause of death (Item 23a) (Type, Print) DEFENSE HIGHWAY AMNARUSM n 21401-8599 ATICK 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

			For State Registrar	State of	f Marylan		artment o			nd Me		jierre	005	14097
	DI		1. Decedent's Name (First, Middle,	ast)							2. Date of Dea Month	ith Day	Year	3. Time of Death
	Physici: /Medic		Beatrice H. M	cClaffer	ty		_				April 2	23, 2	2005	12:20 A M
	Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town							ity, Town, or Location of Death  4c. County of Death				
			TIGHT GOLD TOTAL						Towson Baltir					
	Funeral Director		5. Social Security Number 21 B - 03 - 34 71	.Sex 1 ☐ M 2 💢 F	7. Age (In yrs. 89	last birthday) Yrs.	If Under 1 Y Months D		Under 2 Hours	Min.	8. Date of Birth (Month, Day April 2	, Year)	9. Birtl	hplace (State or Foreign untry) Maryland
	pu 🌬		Usual Residence of Decedent  10a. State 10b. County		10c Cit	y. Town or Lo	cation							10d. Inside City Limits
	shor	5	MD N/A			timore.								1 ⊠ Yes 2 □ No
	the N	Director	10e. Street and Number				10f. Zip Co	ndo.				10a Citiz	en of What Co	
	with	급						1214					JSA	unity:
	leath	era	5512 Sefton Ave		dent Ever in U.	.S. 13. 1				in? (Spec	cify Yes or No-		4. Race - Ame	ncan Indian,
_	r Iten	by Funeral	1 ☐ Never Married 2 ☐ Married	Armed For	rces? 2∭XNo					Puerto P	cify Yes or No- Rican, etc.)		Black, White	e, etc.
3	ours a	by	3 Widowed 4 □ Divorced	If Yes, Giv Year or Da	e ates:		1⊡Yes 2⊠	No S	Specify:				Specify:	White
5-003b	be filed within 72 hours after death with the Maryland at lyglene. By the William "natural", or flems 23a or 28a-f show of other than "natural", or flems 23a or 28a-f show event. The Medical Examinar must be notified at	Completed	15. Decedent's (Specify only highest	Education grade completed)		16a. Deced	dent's Usual O	ccupation	n na most	of workin	a	16b. Kin	d of Business/	Industry
7	vithin ne. hen	du.	Elementary/Secondary (0-12)	College (1	-4or 5+)		kind of work d DO NOT use n	etired)	•					
7	tygler her ti		17. Father's Name (First, Middle, La	2		Secre	etary	10	Mathad	de Name	(First, Middle,		erical	
yland	Q to 0	Be		,				18.			e Viola		,	
چ	2 should be and Mental Is marked reumatic ev	<u>۲</u>	Norman Harper  19a. Informant's Name/Relationship			19h Mailir	na Address (Si	treet and					Town, State, Z	in Code)
Mar	and 2 sealth and 2 substitution 27 is not treu		Robert McClaffe								nore, M		21214	
ā,	- i = =		20a. Method of Disposition			Place of Dispo	sition (Name o	of	1		ate	20c. Loc	ation - City or	Town, State
Ê	Pages nent of ont: If it ury or o		1 ☐ Burial 2 ☐ Cremation 3  4 ☐ Donation 5 ☐ Other (Spe		Siale		alley M		irdns	]4/25	5/2005	Ti	monium.	Maryland
aitimore,	permit. Page Department of Importent: If any injury or once.		21. Signature of Puneral Service Lie								k Tows			Home, Inc.
ñ	Depared Important any ire		MURNER	Stephen	D. Cost	er 1	050 Yo	rk R	≀oad,	, Tou	uson, M	D :	21204	
			23a. Part1. Enter the disease, or co shock, or heart failure. List or	ly one cause on e	ach line.									Approximate Interval Between
-	Pnysician :		Immediate Cause (Final disease or condition	H7718	EROSC	CER	TIC (	COR	INA	2y (	/AGUVI	LAR	SISEME	Onset and Death
	/Medical Examiner		resulting in death)		or as a conseq									
	Lxammer		Sequentially list conditions,	b										
	ed sit	Examiner	n any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (	ui as a cumseq	uarica of).								
	and and III-tran	хап	that initiated events resulting in death) Last	c	or as a conseq	uence of):								
8/60	sician buria	dicai E				•								
200	eath certificate be executed attending physician and for use as the burial-transit	edic		0.										
X Q Q	anding use a	an/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, out			35-4					2	3d. Date of deli	ivery
מ	death le atter	icla	in the past 12 months? 1 ☐ Yes 2 ☐ No		irth 2 ☐ Feta ant at time of d		Ectopic pregr Other (specif						Month	Day Year
J.	res that the de igned by the a be detached f	Physic	9 ⊉Unknown	9CI OUKUC	own	4.5								
Ś	es that gned by be deta	by	Part II. Other significant condition:	s contributing to de	eath but not res	ulting in the u	nderlying caus	se given ir	n Part I.					the cause of death?
ord C	w requires been sign should be	ted									1 L Y	es 2L	No 3 ☐ Pro	obably 4 Donknown
Hecord	aw as b	Completed								_	24a. Was a autop	sy	prior to d	topsy findings available completion of cause of
=	ate pa	Co									perfor	med? 2 No	death?	2□ No
Vital	Physiclen: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:				0.0			(Check only or			
_	hys his	. To	1 ☐ Yes 2 ☑ No 27. Manner of Death	28a. Date o		ER/Outpatier 28b. Time of					ne 5 Resid 8d. Describe h		Other (Spec	cify)
U <sub>O</sub>	ding l h. After funer	tlon	1 ☑ Natural 5 ☐ Pending	(Mont	h, Day Year)	Injury	M 200.	Injury at Work?	2 □ N	- (	od. Describe ii	OW III;ui y	occurred	
DIVISION	Attend death ctor: y the	fica	3 ☐ Suicide 6 ☐ Could no	be on Diese	of Injury - At he	ome, farm, str		-					Number or Ru	ıral Route Number,
2	spitel or Al ours after oner land of the control of	Certification;	4 Homicide		ng, etc. (Specif		,,,				City or Tow	n, State)		
	2 5 5	al C	29a. Certifier 1 Certifying (Check only 2 Medical Fa	Physicien: To the	best of my kno	wledge, deat	n occurred at t	he time, o	date and	place, a	nd due to the o	ause(s)	and manner as	stated.
	To the Hos within 24 ho To the Fun completely	edical	one)	aminer: On the ba and mann	asis of examina her stated.	ition and/or in	vestigation, in	my opinio	on, death	n occurre	d at the time, o	ate and	place, and due	to the cause(s)
	To the within 2 To the complet	Σ	29b. Signature and title of certifier	~l			29c. Li	icense nu	neómu		4	29d. Date	signed (Month	n, Day, Year)
	1		Young Cheen				Þ	XGE	056	50	A	PRI	L 23,	2005
1	U		30. Name and address of person wh			n 23a) (Туре,	Print)  SACK 1	0 11 00	V	N=-	יוג וגי	A 40	.00.00	2 12 * 1
V	)		PANIAI KHE 31. Date filed (Month, Day, Year)	TERPAL 32. R	201-1	iture •	>MUK 1	-175	1	1450	16 'JL	01-15	144(1)	1-21221
	Sta Registi		APR	2 6 2005	Berein		Spark							

			1 - State of Maryland / Dep State of Maryland / Dep Ce	eartment of Health and Mertificate of Death		72005 14098
	Physicia /Medic		1. Decedent's Na <i>me (First, Middle, Last)</i> Floyd Frank Morgan	1	2. Date of Death Month April 2	Day Year 2005 1:20 P. M
	Examin		4a. Facility Name (If not institution, give street and number) 5704 Phillips Street	4b. City, Town, or Location of Death Baltimore		4c. County of Death Anne Arundel
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday 11 M 2 F 53 Yrs.	y If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Y	ear) 9. Birthplace (State or Foreign Country) Maryland
	Maryland f show	tor	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or L  Maryland Anne Arundel Baltim			10d. Inside City Limits 1 ☐ Yes 2X No
	with the a or 28a. be notif	Direc	10e. Street and Number 5704 Phillips Street	10f. Zip Code	10g	. Citizen of What Country?
9	iges 1 and 2 should be filed within 72 hours after death with the Maryland it of Heelih and Mental Hyglene.  If Item 27 Is marked other than "neturel", or Items 23a or 28a-f show or other traumatic event, the Medical Evan	/ Funerai	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Never Married 2 ☑ Married 1 □ Yes 2 ☒ No	21225  Was Decedent of Hispanic Origin? (Spelf Yes, specify Cuban, Mexican, Puerto  □ Yes 2√2 No Specify:	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.  Specify: White
Maryland 21215-0036	in 72 hours "neturel", edical Era	Completed by	(Specify only highest grade completed) (Giv	edent's Usual Occupation e kind of work done during most of worki DO NOT use retired)	ing 16	b. Kind of Business/Industry
1212	iled with Hygiene. Iher ther nt, the M	Com	Elementary/Secondary (U-12)   College (1-4or 5+)	lyst		omputer Programer
ylanc	ould be f Mental H arked ot atic ever	To Be	Donald Morgan		ice Quasn	·
	nd 2 sho alth and 27 Is m			ling Address <i>(Street and Number or Rura</i> Phillips Street		e, Maryland 21225
nore,	Pages 1 and the Head of Head and: If Item		I Li Bullati 2 (Li Cremation 3 Li Reinoval Itolii State	ematory or other place)		c. Location - City or Town, State
Baltimore,	permit. Pages 1 and 2. Department of Heelth ar Importent: If Item 27 is eny injury or other traconce.			Crematory 4/27/ 22. Name and Address of Facility Go		altimore, Maryland ral Service, P.A.
	<u>•</u> □ = • •		23a. Fart1. Enter the disease or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.			more, Maryland 21225 Approximate
	Pnysician /Medical Examiner			IC RECTAL CA.		Interval Between Onset and Death
8760,	ate be executed shysicien and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underthing Cause (Disease or injury that initiated events resulting in death) Last  b. Due to (or as a consequence of):  C. Due to (or as a consequence of):			
O. Box 68	ne death certific the attending p thed for use as	Physician/Medi		□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year
s, P.	quires that the signed by ald be detacted.	by	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		cco use contribute to the cause of death?
Record	The law requir ate has been s page 2 should	Completed	HEART FAILURE		24a. Was an autopsy performe	24b. Were autopsy findings available prior to completion of cause of death?  No 1 □ Yes 2 □ No
Vital	certific rector.	o Be C	25. Was case referred to medical examiner?  1 \( \triangle \triang	Othor	(Check only one)	
Division of	Attanding Physic death.  Cotor: After this by the funeral di	-	1 Yes 2 No Tosynati 1 Inpatient 2 ER/Outpatie  27. Namer of Death 28a. Date of Injury (Month, Day Year) Injury 2 Accident investigation	of 28c. Injury at	28d. Describe how	ae 6 □Other (Specify) injury occurred
Divis	after death after death Director: d in by the	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	treet, factory, office	28f. Location (Stree City or Town, S	et and Number or Rural Route Number, State)
	To the Hospitel or Attanding Phwithin 24 hours after death. To the Funerel Director: After the completely filled in by the funeral	Medicai C	29a. Certifier (Check only one)  Certifying Physician. To the basis of examination and/or in and manner stated.	ith occurred at the time, date and place, nvestigation, in my opinion, death occurr	and due to the caused at the time, date	se(s) and manner as stated. e and place, and due to the cause(s)
	To the within 2. To the I complet	Me	29b. Signature and title of certifier	29c. License number	29d	Date signed (Month, Day, Year)
	1		30. Name and address of person who completed cause of death (Item 23a) (Type	a, Print)	1000	pric 25, 2005 Verge Bacra,
	Sta Registr		31. Date filed (Month, Day, Year)  APR 2 6 2005  32 Jegistrar's Signature	parli)	MIC A	2745

	1 - State Registramend item #23e per phy g843 5	Guirate of Death	Re 2. Date of Death	g. No.	3. Time of Death
Physician	Qun Meng		Month	Day Year 17, 2005	4:17 A M
/Medical Examiner	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	117111	4c. County of Dea	
	Montgomery Hospice Casey House	Rockville		Montgome	ry
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last birthda 2 № F 84 Yrs.	y) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, May 6,	Year) 9. Bir 1920 Ch	hplace (State or Foreigr puntry) Ina
72 hours after death with the Maryland natural; or Items 23a or 28e-f show slical Exercitrent sast be notified at steed by Funeral Director	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or				10d. Inside City Limits
s 23a or 28e-f show wat be nuffilled at ral Director	Maryland Montgomery Potoma				1 ☐ Yes 2 ☒ No
herofilia benefita	10e. Street and Number	10f. Zip Code	10	og. Citizen of What Co	puntry?
3a o	10437 Heathside Way	20854		United Sta	ites
	11. Marital Status 12. Was Decedent Ever in U.S. 13. Armed Forces?	B. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit	
b y	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒ No 3 ☒ Widowed 4 ☐ Divorced Year or Dates:	1 ☐ Yes 2 ☒ No Specify:	,		sian
t, the Medical Ext	15. Decedent's Education 16a. De (Specify only highest grade completed) (Gi	edent's Usual Occupation	ina 1	16b. Kind of Business	
vent, the Ma	Elementary/Secondary (0-12) College (1-40r 5+)	re kind of work done during most of work  DO NOT use retired)		China Publ Schools	10
or, the	12 Te	acher 18. Mother's Name			
atic even	Yuntao Meng	Xinyi		aldon Camamo,	
reumatic ever	19a. Informant's Name/Relationship (Type, Print) 19b. Ma	iling Address (Street and Number or Run		City or Town, State,	Zip Code)
lem 27 li other tre	Xun Ru Qian / Daughter 1043	7 Heathside Way, P	otomac,	Maryland 2	0854
i di	20a. Method of Disposition 1 □ Burial 2 ☒ Cremation 3 □ Removal from State  20b. Place of Discemetery, completely, completely	position (Name of April	20 .	20c. Location - City or	Town, State
lury o	`4 □Donation 5 □Other (Specify) Montgomery	Crematorium, Inc. 200	5 E	Bethesda, 1	
Importent; If Item 2 any injury or other ODCB.	21. Signature of Funeral Service Licensee  Mol 1305	22, Name and Address of Facility Obert A. Pumphrey Funer '557 Wisconsin Avenue, I	al Home/B Bethesda. N	ethesda-Chev Maryland 2081	y Chase, Inc.
	23a. Part 1. Enter the disease, or complications that caused the death. Do not a shock, or heart failure. List only one cause on each line.				Approximate Interval Between
sician	Immediate Cause (Final disease or condition Stage IV Adeno	carcinoma of the L	ungs		Onset and Death
edical miner	resulting in death)  Due to (or as a consequence of):				
0.00	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):				
nsit nIne	Cause (Disease or injury				
ial-transit	that initiated events resulting in death) Last C. Due to (or as a consequence of):	<del> </del>			
is the burial-transit edical Examir	d				
m 0	12 25 111 2				
Physician/M	IF FEMALE:  23b. Was decedent pregnant  1 □ Live birth 2 □ Fetal death	B Ectopic pregnancy		23d. Date of de	
sici		Other (specify)		Month	Day Year
	Part II. Other significant conditions contributing to death but not resulting in the	underhing cause given in Part I	23e Did tob	acco use contribute to	the cause of death?
6 g	Advanced Head and Neck Cancer	and onlying datase given are are		777 126	obably 4 Unknown
age 2 should			24a. Was an		stancy findings qualitable
mp ga 2			autopsy	prior to death?	itopsy findings available completion of cause of
5 0 1	25. Was case referred to medical	26. Place of Deat	1 Yes 2		2 No
director, pag	examiner? 1		-	nce 6 Other (Spe	cw Hospice
9 7	27. Manner of Death 1 X Natural 5 ☐ Pending (Month, Day Year) 28b. Time Injur	of 28c. Injury at	28d. Describe ho		,,
the fu	2 Accident investigation	M 1 Yes 2 No			
completely filled in by the funeral Medical Certification;	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	28f. Location (Str City or Town,	reet and Number or Ri , State)	ural Route Number,
	29a. Certifier 1 Certifying Physician: To the best of my knowledge, de	ath occurred at the time, date and place	and due to the ca	use(s) and manner as	stated
pletely fill	(Check only one)  2 Medical Examiner: On the basis of examination and/or and manner stated.	investigation, in my opinion, death occurr	ed at the time, da	ite and place, and due	to the cause(s)
Comp	29b. Signature and Kille of certifier	29c. License number	29	d. Date signed (Mont	h, Day, Year)
	Meller-	041218		4/17/0	75
10	30. Name and address of person who completed cause of death (item 23a) (Typ			11 - 11	**
*	Charles Harrison, M.D. 6001 Muncast	er Mill Road, Rocky	ville, Ma	aryland 20	855
State Registrar	31. Date filed (Month, Day, Year)  32. Registrar's Signature	5 farles			

DHMH 17 Rev 1/2001

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hydiene O. O. T.

Physicia		1 - State Unpend Iter 1. Decedent's Name (First, Middle, i					2. Date of Deat	e <b>g. No.</b> h		3. Time of Death		
							Month		Year			
/Medic		Scott Alan Man  4a. Facility Name (If not institution, g			4h City Town or	Location of Death	Thir i	4c. County		08:24 a.™		
Examin	er	Suburban Hospita			Bethesda					County		
Funeral				e (In yrs. last birthday,	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	Tiorrege				
Director		217-46-8823	1 <b>∑</b> M 2□F	46 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, Mar. 20	, 1959	Mary	lace (State or Foreign stry) y Land		
Maryland -f show	ō	10a. State 10b. County		10c. City, Town or L					1	0d. Inside City Limits 1 ☐ Yes 2 🛣 No		
the 286-	Director	Maryland   Montgo	mery	Bethesda	10f. Zip Code		1	0g. Citizen of W	/hat Caus	to/2		
with with												
eeth ne 23	era	7705 Cayuga Aver	1U.E 12. Was Decedent	Ever in IIS 13	20817	ispanic Origin? (Spe		United S		ean Indian,		
permit. Peges 1 and 2 should be filed within 72 hours after deeth with the Maryla Department of Health and Mental Hygiens. Infortent: If Item 27 is marked other than "natural; or Items 23e or 28e-f show fingortent: If Item 27 is marked other than "natural; or Items 23e or 28e-f show any injury or other traumetic event, If a Medical Exercities must be recitified at once.	by Funeral	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🛣 Divorced	Armed Forces?	No To.	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ▼ No	Specify:	Rican, etc.)		k, White,	etc.		
2 hor	ed	15. Decedent's	Education	16a. Dece	edent's Usual Occup	ation		16b. Kind of Bu				
olo 7	Completed	(Specify only highest s Elementary/Secondary (0-12)		(Give	kind of work done of DO NOT use retired	during most of worki !)	ng			,		
i the	E	11	College (1-4or 5		f-Employe	d		Class	sic (	lars		
2 should be filed withlr and Mental Hygiene. Is marked other then aumetic event, Ita Ms	BeC	17. Father's Name (First, Middle, La	st)			18. Mother's Name	(First, Middle, I	Maiden Sumam	э)			
ked a	ToB	Charles John Ma	ertin. III			Virgini	a I oo Di	141027				
mar met	1-	19a. Informant's Name/Relationship		19b. Maili	ing Address (Street				State Zin	Code)		
trau		Virginia Lee Man										
Health tem 27 i		20a. Method of Disposition	cin/nother	20b. Place of Dispe	Cayuga A			Mary Lat 20c. Location -		20817 wn. State		
permit. Peges Department of Importent: If if eny injury or o		1 ☐ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe	cify)	Parklawn Park	matory or other place Memorial	200	$^{23}$ , R	ockvil1	e, M	aryland		
Depa Impo any i		21. Signatu heral Service Licens  22. Name and Address of Facility Robert A. Pumphrey Funeral Home Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avon Bethesda, Maryland 20814-3501  23a. Partl. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  Approximate										
Physician /Medical Examiner		shock, or heart failure. List or Immediate Cause (Final disease or condition resulting in death)	a. Atherosc  Due to (or as	lerotic Ca a consequence of):				est,		Approximate Interval Between Onset and Death		
uted d ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as	a consequence of);								
tificate be executed g physicien and as the burial-transit	edicai Exa	resulting in death) Last	Due to (or as	a consequence of):								
tifical ng phy as th	edi	)										
	an/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	of pregnancy								
ine death certifi by the attending packed for use as	nysici	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at 9☐ Unknown	2 Fetal death 3	□Ectopic pregnancy □ Other (specify)			23d. Date Mon		ny Day Year		
es thet the death of gned by the attend be detached for us	by Physici	1 ☐ Yes 2 ☐ No	4☐Pregnant at 9☐ Unknown	2 Fetal death 3[ time of death 5[	Other (specify)		1	Mor	ith	Day Year e cause of death?		
equiles that the death of on signed by the attend ould be detached for us	ed by Physician/N	1  Yes 2 No 9 Unknown	4☐Pregnant at 9☐ Unknown	2 Fetal death 3[ time of death 5[	Other (specify)		1	Mor	ith	Day Year		
e law requires thet the d has been signed by the ye 2 should be detached	ompleted by Physici	1  Yes 2 No 9 Unknown	4☐Pregnant at 9☐ Unknown	2 Fetal death 3[ time of death 5[	Other (specify)		1 ☐ Ye	Mon pacco use contri ps 2 \( \sum \) No n 24b. W py ned?	ibute to th  3 Proba	Day Year le cause of death? ably 4 Dunknown by findings available inpletion of cause of		
ine iaw requires thet the date has been signed by the page 2 should be detached	e Completed	1  Yes 2 No 9 Unknown	4☐Pregnant at 9☐ Unknown	2 Fetal death 3[ time of death 5[	Other (specify)	en in Part I.	1 Yes 2	Mor pacco use contri ps 2 No ny 24b. Wy phed? d 2 No 1	ibute to th	Day Year le cause of death? ably 4 Dunknown by findings available inpletion of cause of		
ine iaw requires thet the often as been signed by the page 2 should be detached	Be Completed	1 ☐ Yes 2 ☐ No 9 ☐ Unknown  Part II. Other significant conditions  25. Was case referred to medical examiner?	4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal death 3 (time of death 5 (	Other (specify)	en in Part I.	1 Yes 2  (Check only on	Monopacco use contributes 2 No no 24b. Wy ned? d 2 No 1	ibute to th  3 Proba Vere autoprior to concepth?  Yes	Day Year  le cause of death?  ably 4 DUNKnown  psy findings available inpletion of cause of 2 No		
rnysician: ine law requires that the use the the use certificate has been signed by the ral director, page 2 should be detached	To Be Completed	1 ☐ Yes 2 ☐ No 9 ☐ Unknown  Part II. Other significant condition:	4 ☐ Pregnant at 9 ☐ Unknown  s contributing to death b  Hospital:	2 Fetal death 3 (time of death 5 (with the control of the control	Other (specify)  underlying cause give  nt 3 DOA Other	an in Part I.  26. Place of Death  9r. 4 □ Nursing Hor	1 Yes 2  (Check only on	Monor de control de co	whith    Signature   Probin     From the state   Probin	Day Year  le cause of death?  ably 4 DUNKnown  psy findings available inpletion of cause of 2 No		
ng Pnysician: The law requires that the diter this certificate has been signed by the neral director, page 2 should be detached	To Be Completed	1 ☐ Yes 2 ☐ No 9 ☐ Unknown  Part II. Other significant conditions  25. Was case referred to medical examiner? 1 ☑ Yes 2 ☐ No  27. Manner of Death	4 ☐ Pregnant at 9 ☐ Unknown  s contributing to death b  Hospital: 1 ☒ Inpatie  28a. Date of Inju (Month, Da	2 Fetal death 3 (time of death 5 (with the control of the control	other (specify)  underlying cause give  nt 3 DOA  Other	26. Place of Death	1 Yes 24a. Was a autops perform 1 X Yes 2	Monor de control de co	whith    Signature   Probin     Vere autoprior to cone     Application     Yes     Control     Control	Day Year  le cause of death?  ably 4 DUNKnown  psy findings available inpletion of cause of 2 No		
ng Pnysician: The law requires that the diter this certificate has been signed by the neral director, page 2 should be detached	To Be Completed	1  Yes 2 No 9 Unknown  Part II. Other significant conditions  25. Was case referred to medical examiner? 1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending investigal 2 Accident investigal 3 Suicide 6 Could no	4 ☐ Pregnant at 9 ☐ Unknown  s contributing to death b  Hospital: 1 ☒ Inpatie  28a. Date of Inju (Month, Da	2 Fetal death 3 time of death 5 time of death 6 time of death	other (specify)  underlying cause give  nt 3 DOA Other  28c. Injun Worl  M 1	26. Place of Death  27. 4 Nursing Hor  28. 2 No	24a. Was a autops perform 1 X Yes 2 (Check only on me 5 Reside 28d. Describe ho	Monor occurred Monor	ibute to th  3 Probi Vere autoprior to coneath?  We sath?	Day Year  ie cause of death?  ably 4 DUnknown  by findings available inpletion of cause of  2 No		
ng Physician: The law requires that the diter this certificate has been signed by the neral director, page 2 should be detached	To Be Completed	1 ☐ Yes 2 ☐ No 9 ☐ Unknown  Part II. Other significant conditions:  25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No  27. Manner of Death 1 ☐ Natural 5 ☐ Pending investigat	4 ☐ Pregnant at 9 ☐ Unknown  s contributing to death b  Hospital: 1 ☒ Inpatie  28a. Date of Inju (Month, Da	2 Fetal death 3 time of death 5 time of death 6 time of death	other (specify)  underlying cause give  nt 3 DOA Other  28c. Injun Worl  M 1	26. Place of Death  27. 4 Nursing Hor  28. 2 No	1 Yes 24a. Was a autops perform 1 X Yes 2	Monor	ibute to th  3 Probi Vere autoprior to coneath?  We sath?	Day Year  ie cause of death?  ably 4 DUnknown  by findings available inpletion of cause of  2 No		
ng Physician: The law requires that the diter this certificate has been signed by the neral director, page 2 should be detached	Certification; To Be Completed	1  Yes 2 No 9 Unknown  Part II. Other significant conditions  25. Was case referred to medical examiner? 1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending investigat 2 Accident 3 Suicide 6 Could not determine  29a. Certifier 1 Certifying	4 ☐ Pregnant at 9 ☐ Unknown  s contributing to death b  Hospital: 1 ☒ Inpatie  28a. Date of Inju (Month, Da.)  100  28a. Place of Inju 28a. Place	ent 2 ER/Outpatie  y Year)  2Bb. Time of Injury  uny - At home, farm, st (Specify)  of my knowledge, deal of examination and/or if	other (specify)  underlying cause give  nt 3 DOA Other  28c. Injun Worl  M 1   reet, factory, office	26. Place of Death  27. 4 Nursing Hor  vat  vat  vat  vas  2 No	1 Yes  24a. Was a autops perform 1 Yes 2  (Check only on me 5 Reside 28d. Describe no City or Town and due to the cand due to	Mon  pacco use contri  ps 2 No  24b. W  y  phed?  Characteristics  proet and Number	ibute to th  3 Probi Vere autoprior to coneath?  Yes  or (Specify)  at or or Rural	Day Year  is cause of death?  ably 4 Dunknown  by findings available in pletion of cause of 2 No  I Route Number,		
ig Priysician: The law requires met med the the certificate has been signed by the neral director, page 2 should be detached	To Be Completed	1  Yes 2 No 9 Unknown  Part II. Other significant conditions:  25. Was case referred to medical examiner?  1 Yes 2 No  27. Manner of Death  1 Natural 5 Pending Investigat  2 Accident Investigat  3 Suicide 6 Could not determine  29a. Certifier (Check only one)  29b. Signature and title of certifier	Hospital: 1 Impatie  28a. Date of inju (Month, Da)  28e. Place of Inju be be be be be be be aminer: On the basis of and manner sta	ent 2 ER/Outpatie  y Year)  2Bb. Time of Injury  uny - At home, farm, st (Specify)  of my knowledge, deal of examination and/or if	other (specify)  underlying cause give  nt 3 DOA Other  28c. Injun Worl  M 1   reet, factory, office	26. Place of Death  27. 4 Nursing Hor  28. 2 No  29. 2 No	24a. Was a autops perform 1 X Yes 2 (Check only on me 5 Reside 28d. Describe house 128f. Location (St. City or Town and due to the cased at the time, di	Mon  pacco use contri  ps 2 No  24b. W  y  phed?  Characteristics  proet and Number	whith all probabilities and the state of the	Day Year  ie cause of death? ably 4 Dunknown  Day findings available inpletion of cause of 2 No  I Route Number,  ated. the cause(s)  Day, Year)		
ng Physician: The law requires that the diter this certificate has been signed by the neral director, page 2 should be detached	Certification; To Be Completed	25. Was case referred to medical examiner?  1  Yes 2 No  25. Was case referred to medical examiner?  1  Yes 2 No  27. Manner of Death  2  Accident investigal investigal etermine  3  Suicide 6 Could no determine  29a. Certifier (Check only one)  29b. Signature and title of certifier  30. Name and address of person with	Hospital: 1 Impaties 28a. Date of Injunction 28e. Place of Injunction 2	2 Fetal death 3 time of death 5 time of my knowledge, death 6 examination and/or inted.	other (specify)  underlying cause give  nt 3 DOA Other  28c. Injun Worl  M 1 reet, factory, office  th occurred at the timestigation, in my office  29c. License  OCME	26. Place of Death  27. 4 Nursing Hor  28. 2 No  29. 4 No	24a. Was a autops perform 1 X Yes 2 (Check only on the 5 Reside 28d. Describe house 28d. Describe house 28d. Describe house 28d. According to the card at the time, did	Monor pacco use control of 2   No   No   No   No   No   No   No	whith    Solution to the solution of the solut	Day Year  le cause of death? ably 4 Munknown  posy findings available in pletion of cause of 2 No  I Route Number,  ated. the cause(s)  Day, Year)  2005		
Attanding Physician: The law requires that the drawn death. Todash. After this certificate has been signed by the ector. After this certificate has been signed by the funeral director, page 2 should be detached	Medical Certification; To Be Completed	25. Was case referred to medical examiner?  152 Yes 2 No  27. Manner of Death  2 Accident  3 Suicide 6 Could not determine (Check only one)  29b. Signature and title of certifier	Hospital: 1 X Inpatie  28a. Date of Injudenth, Date of Injudenth of Injuden	2 Fetal death 3 time of death 5 time of my knowledge, death 6 examination and/or inted.	other (specify)  underlying cause give  nt 3 DOA Other  28c. Injun Worl  M 1 reet, factory, office  th occurred at the timestigation, in my office  29c. License  OCME  Print)  111 I	26. Place of Death  27. 4 Nursing Hor  28. 2 No  29. 4 No	24a. Was a autops perform 1 X Yes 2 (Check only on the 5 Reside 28d. Describe house 28d. Describe house 28d. Describe house 28d. According to the card at the time, did	Monor pacco use control of 2   No   No   No   No   No   No   No	whith    Solution to the solution of the solut	Day Year  ie cause of death? ably 4 Dunknown  pay findings available impletion of cause of 2 No  I Route Number,  ated. the cause(s)  Day, Year)		

				State of Maryland / Department of Health and M 1- State Amend Item#18, per Inf, G843, 5/3 (95) (Cartificate of Death	1ental Hygi	iene	5	401
		Physicia /Medic		1. Decedent's Name (First, Middle, Last)  ESTE G V C W C	2. Date of Death	h Day	Year	3. Time of Death
		Examin		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death		4c. County	of Death	
				Stella Maris Timonium		Ba	ltim	ore
		Funeral Director		5. Social Security Number 6. Sex 1 M 240 84  7. Age (In yrs. last birthday) 1 If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, January 5	Year) 1921	9. Birthp Court Man	lace (State or Foreign try) Vland
		pq *		Usual Residence of Decedent           10a. State         10b. County         10c. City, Town or Location				01 1-11 01 11
		show and will	Į.				1	0d. Inside City Limits
		28a-1	Director	Maryland Baltimore Timonium  106. Street and Number 10f. Zip Code	1/	Og. Citizen of W	/hat Cour	1 Yes 2 No
		3e or		2300 Dulaney Valley Road 21093		USA		uy:
		death me 2	Funeral	11 Marital Status 12 Was Decedent Ever in U.S. 13 Was Decedent of Hispanic Origin? (Sp.	ecify Yes or No-	14. Race	- Americ	an Indian,
	36	should be filed within 72 hours after death with the Maryland of Mental Hygiene. marked other then "neturel; or iteme 23e or 28e-f show imatic event, the Mudical Examinating the Indillied at	y Fu	1 □ Never Married 2 □ Married 1 □ Yes ※17 No  If Yes, Give 1 □ Yes ※20 No Specify:	HICAN, etc.)	Specify	k, White,	
	21215-0036	hours turel',	ed by	XXWidowed 4 □ Divorced Year or Dates:  15. Decedent's Education 16a. Decedent's Usual Occupation			Wni	
	15	in 72 n "ne Nedic	Completed	(Specify only highest grade completed) (Give kind of work done during most of work)	ing	16b. Kind of Bu	siness/inc	dustry
	212	d with glene ar the	mo:	Elementary/Secondary (0-12) College (1-4or 5+)  6 Homemaker		0wn	Home	
	nd	ould be filed withi Mental Hygiene. arked other then atic event, I'm M	Be	17. Father's Name (First, Middle, Last)  18. Mother's Name (Ciacomo Mastroposi			,	
	yla	should I	L <sub>O</sub>			Theres		
P.M	Maryland	le le le		19a. Informant's Name/Relationship (Type, Print)  Bonnie Gutierrez  Dtr 19b. Mailing Address (Street and Number or Rura 10 Donagh Court Timoni				Code)
		is 1 and 2 should of Health and Men item 27 le marke other treumatic		20a. Method of Disposition 20b. Place of Disposition (Name of		20c. Location -		wn, State
3:00	OLL	Pages nent of I nnt: If its iry or o		XX Burial 2 Cremation 3 Removal from State  A Donation 5 Other (Specify)  Cemetery, crematory or other place)  Grdns of Faith  4/28			•	Maryland
. ,	altimore,	permit. Pages Department of Importent: If it any injury or c		2) Eignature of Funeral Service Licensee 22. Name and Address of Facility Mi				
	<u>m</u>	20 = 3			Road Balt			
		.6		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac of shock, or heart failure. List only one cause on each line.	or respiratory arre	st,		Approximate Interval Between
		Physician		Immediate Cause (Final disease or condition resulting in death)  a. House (Renal tail Us	9			Onset and Death
		/Medical Examiner		Due to (or as a consequence of):				
			er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying  b. Due to (or as a consequence of):				
		be executed sician and burial-transit	Examin	Cause (Disease or injury that initiated events				
	Ó,	cate be executed physician and the burial-transit		resulting in death) Last  Due to (or as a consequence of):				
	8760,	physic the bu	dlcal	d				
10	9 xo	eath certifii attending p for use as	/Me	IF FEMALE: 23b. Was deceded program: 23c. If yes, outcome of pregnancy		004 044		
200	8	leath atten	Physiclan/Me	23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No   1   Yes 2   No   2   Yes outcome or pregnancy   3   Ectopic pregnancy   5   Other (specify)   1   Yes 2   No   1   Yes 2   Yes outcome or pregnancy   3   Ectopic pregnancy   5   Other (specify)   1   Yes outcome or pregnancy   1   Yes outcome or		23d. Date Mon		ry Day Year
5,	O.	at the de by the a tached	hysi	9 ☐ Unknown				
7.	s, P	requires that the death certifi een signed by the attending I nould be detached for use as	by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tob	acco use contr	bute to th	e cause of death?
APRIL	cord	w requir been si should I	ted	House Stroke	1 🗆 Ye	s 2 No	3 Prob	ably 4 Unknown
AF	a)	aw as b	Completed		24a. Was an autopsy	24b. W	ere autor	osy findings available inpletion of cause of
T'	ᄪ				perform 1 Ves 2	100?	eath?	
NEWELL	Vital	Physicien: this certific ral director,	o Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 No 2 N				
NE	of		-	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at	me 5 Resider 28d. Describe how			")
L'A	sion	Attending F r death. sctor: After by the funer	atlo	1 ⊠Natural 5 □ Pending (Month, Day Year) Injury Work? 2 □ Accident investigation M 1 □ Yes 2 □ No				
ESTELLA	Divis	I or Attend after death Director: ,	ertification;	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Str. City or Town,	eet and Numbe State)	r or Rura	Route Number,
ESI		ital or urs afte rel Dir lled in	O					
		Hospital 24 hours a Funerel (	edical	29a. Certifier  (Check only one)  Amedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	and due to the car ed at the time, da	use(s) and mar te and place, a	ner as st nd due to	ated. the cause(s)
_		To the Hospital or / within 24 hours after To the Funeral Dire completely filled in b	Me	29b. Signature and title of certifier / 29c. License number	29	d Date signed	(Month, I	Day, Year)
	)		1	Frestive Wight MD DS274	0 1	MM	SS	In 5002
	į	1		30. Name and address of person who completed cause of death (them 23a) (Type, Print)		4		
					ONIUM, N	<i>ID</i> 2109.	3	
		Sta Registr		31. Date filed (Month, Day, Year)  APR 2 6 2005				

# Timothy Neighoff Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

004			1 - State Unpend Item Registrar	State of Ma 23a&27 per	aryland/Depa me G8435	artment of F -25-05 to rtificate of	lealth and M Death	ental Hy	giene 0 (	5	14102
	Physici		1. Decedent's Name (First, Middle, Last Timothy David					2. Date of De Month April	Day	Year 5	3. Time of Death 12:00 P M
5	/Medic Examin		4a. Facility Name (If not institution, give North Arundel Hos) 5. Social Security Number 6. S	pital	ə (In yrs. last birthday)	Glen Bui	If Under 24 Hrs.		4c. County of	of Death Arun	del
3	Director			TM 2DF	36 Yrs.	Months Days	Hours Min.	(Month, Da March	y, Year) 27, 1969	Mar	lace (State or Foreign try) Yland  Od. Inside City Limits
	death with the Maryland ms 23a or 28a-f show rmust be rediffed at	ctor	,	rundel	Pasade					'	1 ☐ Yes 2√2 No
	with the	Directo	10e. Street and Number			10f. Zip Code			10g. Citizen of W		itry?
	ns 23	Funerai	140 Park Road	12. Was Decedent I	Ever in U.S. 13.	21122 Was Decedent of F		cify Yes or No	- 14. Race		an Indian.
9036	ours after ret', or ite Everalize	þ	1 Never Married 2 🔀 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2(1) If Yes, Give Year or Dates:	10	If Yes, specify Cuba 1 ☐ Yes XXX No	fispanic Origin? (Spe an, Mexican, Puerto f Specify:	Rican, etc.)	Specify:	c, White,	
215-(	m = 30	Completed	15. Decedent's Ec (Specify only highest gra		(Give	dent's Usual Occup kind of work done DO NOT use retired	pation during most of workind)	ng	16b. Kind of Bu	siness/Ind	dustry
21	e filed within Il Hygiene. othar than vent, the Ma	Com	Elementary/Secondary (0-12)		E	lectricia	· · · · · · · · · · · · · · · · · · ·		Const		ion
/land	7 5 D 9	To Be	17. Father's Name (First, Middle, Last) Shawn Raymor		ff		18. Mother's Name Jao		Maiden Sumame ie Ann Bi		
, Mar	ges 1 and 2 should t of Health and Mer if item 27 is marke or other treumatic		19a. Informant's Name/Relationship ( Shawn Neighoff	Type, Print) Father	4	446 Newpo	and Number or Rura ort Avenue	Balti	.more, Ma	aryla	and 21211
Baltimore, Maryland 21215-0036	Pa men ury		20a. Method of Disposition  1 △ Burial 2 ☐ Cremation 3 ☐  1 ☐ Donation 5 ☐ Other (Specification of Creating of Cr	1)		"Wall'ey pla 1 Gardens	4/26/		Timonium	n, Ma	ryland
Bal	permit. Departr Importo any inji		21. Signalure of Funeral Service Licer	Hen	33) 2	Burgee-He 3631 Fall	enss-Seitz S Road, B	Funera altimor	1 Home, e, Maryl	Inc.	21211
	Physician /Medical		23a. Part1. Enfer the disease, or com shock of heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. Intracer	the death. Do not entre.  rebral Hemo a consequence of):		ng, such as cardiac o	r respiratory a	rrest,		Approximate Interval Between Onset and Death
	Examiner	iner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as	а солнециялся обу						
68760,	ificate be executed g physician and as the burial-transit	edical Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as	a consequence of):						
	ifica g ph as th		IF FEMALE:								
.O. Box	it the death certifi by the attending tached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months?  1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal death 3	Ectopic pregnancy Other (specify)	/		23d. Date Mon		ny Day Year
ords, P	law requires that the as been signed by th 2 should be detache	by	Part II. Other significant conditions of	ontributing to death b	ut not resulting in the u	nderlying cause giv	en in Part I.			bute to th	e cause of death?
of Vital Records,	The ate h	Completed							DSV D	nor to cor eath?	psy findings available appletion of cause of
Vita	Physician: 1 this certifical ral director, p	Be	25. Was case referred to medical examiner? 1    Yes 2   No	Hospital:	-t of 750/0 to 1	Ott	26. Place of Death				
ion of	nding uth. r: After e fune	ation: To	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Inju (Month, Da		f 28c. Injur	4   Nursing Hon		dence 6 Othe		/)
Division	tal or Attenus after death	Certification:	3 Suicide 6 Could not b 4 Homicide determined	28e. Place of Injubulding, etc	ury - At home, farm, str c. (Specify)	eet, factory, office	2	28f. Location (S City or Tov	Street and Numbe vn, State)	r or Rura	l Route Number,
	ins Hospital or in 24 hours afte the Funeral Diru plately filled in b	edical	29a. Certifier 1 Certifying Ph (Check only one) 1 Medicel Exar	ysician: To the best niner: On the basis of and manner sta	of my knowledge, deat i examination and/or in ated.	h occurred at the tir vestigation, in my o	me, date and place, a opinion, death occurre	and due to the ad at the time,	cause(s) and mar date and place, a	nner as st	ated. the cause(s)
	To the within 2 Fo the complet	×	29b. Signature and title of certifier	`		29c. Licens	e number		29d. Date signed April 22		
6	Son			310,MD		111	Penn Stree	et Bal	timore,	Mary.	land 21201
	Sta Registi	1 13	31. Date filed (Month, Day, Year)  APR 2 6 2	32 Registra	ar's Signature	wie					

			1 - State Registrar	of Maryland		rtment of Ho		Mental Hy	giene	15	1410	3
			Decedent's Name (First, Middle, Last)					2. Date of De	ath		3. Time of Dea	ath
И	Physici /Medic		Charles Edwin Nicklas					Month April	24 <b>,</b> 2005	Year D	2:30 A	. м
	Examin		4a. Facility Name (If not institution, give street and	number)		4b. City, Town, or	Location of Deat	h	4c. County of Death			
			Shady Grove Adventist			Rockvil.			Monte	gomer	у	
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. la	ast birthday) Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Bir (Month, Da Oct. 3	th ay, Year)	Cour	place (State or For	-
	Director		233-34-1121 Usual Residence of Decedent	81	115.			Oct. 3	, 1923	Penns	sÿlvania	
	/land		10a. State 10b. County	10c. City	, Town or Lo	cation				1	0d. Inside City Li	mits
	Man P-f sh	ţċ	Maryland Montgomery	Pot	tomac						1 □ Yes 2 🛚	No
	th the	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of	What Cour	ntry?	
	23a	ai	11901 Gainsborough Road	1		20854			United	State	s	
	tama tama	Funeral	Amed	ecedent Ever in U.S Forces?	S. 13. V	Vas Decedent of His Yes, specify Cubar	spanic Origin? (S n, Mexican, Puerl	pecify Yes or No to Rican, etc.)		ce - Americ		
36	', or i	by F	If Voc	s 2⊡No Give rDates:WW II	.   .	☐Yes 2XNo	Specify:		Specif	ీ∵ Whit	t e	
9	thou stura	edit	15. Decedent's Education	1 Da(63. 1111 11	16a, Deced	lent's Usual Occupa	tion		16b. Kind of B			
212	nin 72 In "na	Completed	(Specify only highest grade complete	a (1-4or 5+)	(Give life. L	kind of work done d OO NOT use retired)	uring most of wo	rking	100111111111111111111111111111111111111		acony	
21	d with	mo.	2	3 (1-40134)	Foreig	gn Servic	e Office	r	Federa.	1 Gov	ernment	
D	be file tal Hy d oth	Be	17. Father's Name (First, Middle, Last)				18. Mother's Nar			πe)		
₹ Z	Men Merke Marke	ဥ	Charles Edwin Nicklas		-		Gertrud					
Maryland 21215-0036	12 sh h and 7 is m traum		19a. Informant's Name/Relationship (Type, Print)	/D1-+	1	g Address (Street a			-		-	
ė,	1 and Healt em 2		Nancy Margaret Nicklas	20b. PI	ace of Dispo	Racetec (	e 24		20c. Location			-
nor	ages ant of t: If it		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal fro 4 ☐ Donation 5 ☐ Other (Specify)	m State   Gat	e of I	leaven		il <sup>ate</sup> 30,			Marylan	nd.
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: if Item 27 is marked other than "natural", or Itama 23a or 28e-f show says injury or other traumatic event, the Medical Exacting mast be retilled at 2006.	i	21. Signature of Funeral Servi & Licensee	Cer	netery	. Name and Address	,			-	-	
ä	Deg Find Page		MACh.	M01353	R C	Name and Address OCKVIIIE, OCKVIIIE,	Inc.	00 West nd 20850	Mont 2011 - 2805	rery"	lvenue"	
			23a. Part1. Enter the disease, or complications the shock, or heart failure. List only one cause of	at caused the death	. Do not ente	er the mode of dying	, such as cardia	or respiratory a	rrest,	10	Approximate Interval Between	
3	Physician :		Immediate Cause (Final disease or condition	whas	Jan	cla	loud	and	OM.	3 /	Onset and Death	
	/Medical Examiner		resulting in death)	to (or as a consequ	ence of):						1100	1000
	Examine	_	Sequentially list conditions, b.									
Т	bei tist	nine	If any, leading to immediate cause. Enter Underlying Cause (Disease or injury	to (or as a cons <u>aq</u> u	enge our							
	al-trai	Examiner	that initiated events c.	to (or as a consequ	ence of):							
8760,	icate be executed physician and s the burial-transit	dicai E	d									
9	tificat ng phy as th	ledi										
Вох	eath certific attending p for use as	an/N	20b. Was decadent pregnant	outcome of pregnar		Ectopic pregnancy				ate of delive		
о. П	e dea the att	sici		egnant at time of de		Other (specify)			Mo	onth	Day Year	
<u>а</u>	The law requires that the death certific ate has been signed by the attending p page 2 should be detached for use as	Physician/Me	Part II. Other significant conditions contributing to	death but not recu	Iting in the ur	doching anung sixo	n in Port I	230 Did 9	lahassa usa san	tributo to th	ne cause of death	2
Records,	signe d be d	d by	Schola	J dodn't but not 1830	iting in the di	idenying cause give	iiiir caiti.	1 🗆	1	_	ably 4 Unknown	
200	w require been si should I	ete	7000		-							
Re	The lav	Completed						24a. Was auto perfo	psy ormed?	prior to cor death?	psy findings avail npletion of cause	of
Vital			25. Was case referred to medical				26 Place of Doc	1 ☐ Yes		1 🗆 Yes	2 No	
	ysicis is cer direct	To Be	examiner?	□ Impatient 2 □ E	ER/Outpatien	t 3 DOA Othe	r	lome 5 ☐ Resi		ner (Specif	v)	
0	Attanding Physician: or death. octor: After this certific by the funeral director.		27. Manner of Death 28a. Da	te of Injury lonth, Day Year)	28b. Time of Injury	28c. Injury Work	-		how injury occur		·/	
<u>S</u>	uttandir death. ctor: Al y the fu	catic	2 Accident investigation				es 2 No					
Division of	i or Attandater death Director: Jin by the	Certification:	determined 288. Pla	ace of Injury - At hor ilding, etc. (Specify	me, f <i>ar</i> m, stro )	eet, factory, office		28f. Location ( City or To	Street and Numb wn, State)	oer or Rura	l Route Number,	
	pitei ours a aral [		29a. Certifier 1 Certifying Physicien: To	the heat of my leave				- 11 11				
	To the Hospitel or within 24 hours after To the Funaral Dirticompletely filled in the completely filled in the completely filled in the form the fo	Medical	(Check only 2 Medical Examiner: On the	basis of examinati anner stated.	ion and/or inv	estigation, in my op	e, date and place inion, death occu	irred at the time,	date and place,	and due to	ated. the cause(s)	
	Nithin Fo th	Me	29b. Signature and title of certifier			29c. License	number		29d. Date signe	d (Month,	Day, Year)	
			1 Unel	rou	N	1	3322	4 1	APRIL.	24.	2005	
	,14		30. Name and address of person who completed c	ause of death (Item			~ 1:	200	0		- 00	
	14+1		KAMTKEHAN MD	50 W	Edr	nonster	1 D8-#	303	ROCK	-U(U	2005 LE 1410:	20
	Sta Registr			Registrar's Sonat	ure	1. Coule						4
			7 11 11 10 V L		1000 100	1						- 1

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Year Francis Joseph Orange April 15. 2005 /Medical 11:55 A.M 4a Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Deeth 4c. County of Deeth Examiner Charles County Nursing & Rehab Center Charles Waldorf If Under 24 Hrs If Under 1 Year 5. Social Security Number 6. Sex 7. Age (In yrs. lest birthday) Birthplace (Stete or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours \* M 2□ F 578 18 2139 85 Director April 20, 1919 Washington DC Usuel Residence of Decedent Peges 1 and 2 should be filed within 72 hours efter deeth with the Maryland nent of Health and Mantai Hygiana. 10a. State 10b. County 10c. City, Town or Location show 10d. Inside City Limits 7 is marked other than "natural", or flems 23a or 28e-f shor traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No XX Maryland Charles Directo LaP1ata 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 10200 LaPlata Road 20646 United States Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ≥ Zi No If Yes, Give Year or Detes: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 X No Specify: 2 3 Hidowed 4 □ Divorced Specify: White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry al Hygiana. Elementary/Secondary (0-12) College (1-4or 5+) Machinist 12 Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden, Surname) August Orange Kessi Vallandingham

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) important: if item 27 is m any injury or other 19a. informant's Name/Relationship (Type, Print) Marilynda Macquade (Daughter) 10851 Alyssa Lane, Waldorf, Maryland 20603 20a. Mathod of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) April 22. Date 2005 20c. Location - City or Town, State Clinton, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Resurrection Cemetery 22. Name and Address of Facility Lee Funeral HOme, Inc. 6633 01d 21. Signature of Funeral Service Licensee MO 1422 Alexandria Ferry Rd, Clinton, Maryland 20735 23a Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Examiner physiclen end s the buriel-transit Attending Physician: The law requires thet the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as a consequence of): attanding p signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 Probably 4 Unknown 2 paga 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Was an autopsy performed? 2 No certificata 1 Yes 1 ☐ Yes 2 ☐ No funerel director. 25. Wes case referred to medical 26. Place of Death (Check only one) Hospital: Other: XX Nursing Home 5 - Residence 6 - Other (Specify) 1 ☐ Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28e. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Naturel 5 Pending To the Hospital or Attendin within 24 hours after deeth. To the Funeral Director: Aft completely filled in by the fu 2 Accident investigation 1 Yes 2 No 3 ☐ Suicide 6 Could not be determined Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicat Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie edical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Yeer) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5625 Allentown Road Suite1011, Camp Springs, MD 20746 Fatima Hussein, M.D. 31. Dete filed (Month, Day, Year) 32. Registra Signature State Registrar

DHMH 16 Rev 6/95

**Physician** Harold Avery Osborne 7:35 AM 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner itizans 6 1000 Tome Tav de ac a If Under 24 Hrs. If Under Year 8. Date of Birth (Month, Day, Oct. 11 9. Birthplace (State or Foreign Country) 1913 North Carolina 7. Age (In yrs. last birthday, **Funeral** Min. 1√2 M 2 □ F Days Hours 91 Director Usual Residence of Decedent 10c. City, Town or Location 10a, State 10b. County Show 10d. Inside City Limits r 28e-f show Maryland Harford Churchville 1 ☐ Yes 2 X No Director 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? r than "natural", or items 23e or 720 Calvary Road 21028 USA 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) hours after 1 Never Married 2 Married 1 Types 2 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 25 No Specify: White Specify: è 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Laboratory Technician U.S. Government 11 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be fill ment of Health and Mental Hitant: If item 27 is marked ott Floyd (NMN) Osborne Virgie O. Jones 19a. Informant's Name/Relationship (Type, Print) EXECUTOY 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nancy F. Pace/Sister-In-Law 1413 Emily Court West, Abingdon, MD 21009 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) permit. Page Department of Important: If any injury or once. Bel Air Mem. Gardens | 4-25-2005 Bel Air, MD of Funeral Service Licensee 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, MD 21009 Williamas 23a. Part 1. Enfor the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Morver Priysician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ue to (or as a consequence of Examiner ed by the attending physician and detached for use as the burial-transit Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 9 Unknown 9 DUnknown sborne, Harold Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy 1 Yes 1 Yes 2 DH 2 DK funeral director. 25. Was case referred to medical examiner. Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home Certification: To 1 TYes 2 NO 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) After this To the Hospital or Attending Pt within 24 hours after death.

To the Funeral Director; After th completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 27. Manuer of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No invest gation 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Proceeding Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29d. Day signed (Month, Day, Year) 10+1 who completed cause of death (Item 23a) (Type, Print) 44 62

amend Riese Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

Year

2. Date of Death

State

Registrar

31. Date filed (Month, Day, Year)

APR 26

2005

1 - For Stete Registrar

1. Decedent's Name (First, Middle, Last)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month Day O'Connell 20, Ethelvn Marie 2005 April 1:02 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Holy Cross Hospital Silver Spring Montgomery If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) August 02, 1922 Birthplace (State or Foreign Country) **Funeral** Days 1 ☐ M 2 🖾 F 502-14-1092 82 Vrs Director North Dakota Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28e-f show treumatic event, the Madical Examiner must be notified at 1 ☐ Yes 2 No Directo Maryland Montgomery Kensington 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? 5 20895 or items 23a 11226 Waycross Way United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year, or Dates: Race - American Indian, Black, White, etc. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) e filed within 72 hours after at Hygiene. other then "natural", or ite 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White δ 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 2 should be f and Mental F is marked of Clifford Peterson Unk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) s 1 and 2 s of Health an item 27 is Margaret Evelyn O'Connell/daughter 11226 Waycross Way, Kensington, Maryland 20895 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) April 24 permit. Pages 1
Depertment of He
importent: if iten
any injury or oth 20c. Location - City or Town, State 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) Montgomery Crematorium, Inc. 2005 Bethesda, Maryland 21. Signature of Fungral Service Licenses Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. M01305 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501 Interval Between Onset and Death Immediate Cause (Final **Physician** Sepsis Syndrome disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Aspiration Pneumonia Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of). Examine The law requires that the death certificate be executed use as the burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, the attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☒ No Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. | 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ģ pe ( Advanced Carcinoma of Breasts, Carcinoma of the page 2 should Completed 1 Yes 2 No 3 Probably 4 Unknown Colon, Dementia, Diabetes Mellitus, Peripheral 24b. Were autopsy findings available prior to completion of cause of death? certificate has autopsy performed' Vascular Disease Division of Vital 1 Yes 2 No 1 Yes 2 X No the Hospitel or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: To 1 X Yes 2 □ No 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred After 1 X Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours a e Funerel [ 29a. Certifier 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medica 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2 enan D53367 April 21, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) r 10810 Darnestown Road, Suite 202, Gaithersburg, Maryland 20878 Shyamsundar Rajan, M.D. Joseph 32 Registrar Signature State 6 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year 734 **Physician** a M Puryear ORIL Isabell 2005 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) City, Town, or Location of Death **Examiner** NA General saltimore Jakyland If Under 1 Year | If Under 24 Hrs: Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) 5. Social Seconty Number 6. Sex **Funeral** Days Hours Months 1 □ M 20 F 228-22-4438 85 Director 12-26-19 Va Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a State 28a-f show treumatic event, the Madical Examiner must be notified at 1 Yes 2 No Director Baltimore NA Md. 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20 422 IISA 1300 E. Lanvale St. Apt. 21202 or Items 23a Completed by Funeral death 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 72 hours after ☐Yes 2 No f Yes. Give 1 Never Married 2 Married 1 ☐ Yes X☐ No Specify: Specify: Black 3√ Widowed 4 Divorced Year or Dates: "naturel". 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. filed within Elementary/Secondary (0-12) College (1-4or 5+) Factory Clothing 6th grade 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be should be f nd Mental 1 Jefferson and Mental Ada Carter Everette 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1722 E. 28th Street, Baltimore, Md. Pages 1 and 2 Daughter item 27 Grace Morris Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Department of Important: If it any injury or o 6 1 \ Burial 2 □ Cremation 3 □ Removal from State
4 □ Donation 5 □ Other (Specify) 4-26-05 Randallstown, Md. King Mem. Park 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Baltimore, Md. 1101 E. North Ave. Blade March F.H. East 00 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed use as the burial-transit Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month Year ģ in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) P.O. 1 9 Unknown 9 Unknown þ 23e. Did tobacco use contribute to the cause of death? signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part II. þ Records, 1 ☐ Yes 2 ☐ No 3 Probably 4 Dunknown page 2 should Be Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Jas 1 ☐ Yes 2 2 No certificate Division of Vital Hospital or Attending Physician: director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To his 28a. Date of Injury (Month, Day 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred funeral 27. Manner of Death After 1 DNatural 5 Pending investigation 2 🗌 No 1 Tyes death. 2 Accident Director: 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 T Homicide 24 hours a 12 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medicai To the within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 211 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ou 82. Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/200

Registrar

APR 2 6 2005

	1- For Amend Items#17&18, per FH, G843 Certificate of Death	nd Mental Hygien	2005 14108
Physician /Medical			Day Year 3. Time of Death 4:384 M
Examiner	4a. Facility Name (If not institution give street and number)  4b. City, Town or Location of SACTIME  ADDITIONAL STREET OF THE S	OKE	4c. County of Deeth
Funeral Director	5. Social Security Number  2.0. 2. 9360  1 M 2 F 7. Age (in yrs. last birthday) Yrs.    If Under 1 Year   If Under 2 Year   Months   Days   Hours	Min. 8. Date of Birth (Month, Day, Yea	9. Birthplace (State or Foreign North CAROLINA
Maryland f show	10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits 1 ☐ Yes 2 🎛 No
with the Mar 3a or 28a-1 si It te motifical	10e. Street and Number 10f. Zip Code 207.		Citizen of What Country?
1215-0036 within 72 hours after death with the Maryland ane. than "natural", or items 23a or 28a-1 show in Modical Examility must be notified at morpheted by Funeral Director	11. Marital Status 1	n? (Specify Yes or No- Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.  Specify: DLACK
Maryland 21215-0036 at 2 should be filed within 72 hours aft th and Mental Hygiene.  27 is marked other than "natural", or traumatic event, fre Macical Example To Be Completed by F	15. Decedent's Education (Specify only highest grade completed)  Elementary/Sacandary (0-12)  College (1-4or 5+)  16a. Decedent's Usual Occupation (Give kind of work done during most of life. DO NOT use retired)  NVISE ADE	of working	Kind of Business/Industry HEAUTH CARE
aryland 2 should be filed 1 and Mental Hygier marked other matic event, II	17. Father's Name (First, Middle, Last) RODERT T. N. Adams	ider Mardecia Mork Do	
	1992. Informant's Name/Relationship (Type, Print)  DERTHA TENSON   SISTER   8255 LINCOLN D	K. JESSUA	MARYLAND 20794
Pages nent of ant: If it		4.29.05 EL	Location - Oity or Town, State  KRIDGE , MAK-YCANO
Balti Permit. Departr Importe any inju		OAD BALTIMO	SREENE FUNERAL HONE PRE, MARYLAND 21212
Physician	23a. Part1. Enter the disease, of implications that caused the death. Do not enter the mode of dying, such as caused the death. Do not enter the mode of dying, such as cause one of the such disease or condition.    Immediate Cause (Final disease or condition		Approximate Interval Between Onset and Death  UEACS
/Medical Examiner	Due to (or as a consequence of):		
0, executed en and rial-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):		
876 ate be ate be the but the	d		
O. Box O. Box he death cent the attendin thed for use.	IF FEMALE: 23b. Was decedent pregnant in the past 12 menths? 1   Yes   2   Z   No   9   Unknown   2   Z   No   9   Unknown   3   Ectopic pregnancy   1   Live birth   2   Fetal death   3   Ectopic pregnancy   1   Pregnant at time of death   5   Other (specify)   9   Unknown   9   Unknown		23d. Date of delivery Month Day Year
ds, P. dires that the signed by id be detacted by Physical by Phys	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  Alzheimer 'S Discase	23e. Did tobacc	co use contribute to the cause of death?  2 No 3 Probably 4 Harknown
		24a. Was an autopsy performed 1 Yes 2	
of Vital Of Vital Physicien: This centificate ral director, pr	25. Was case referred to medical examiner?	of Death (Check only one) sing Home 5 \( \subseteq \text{Residence} \)	6 (Sother (Specify) +050 ice
Vision of Vision of Attending Phy redeath. Sector: After this by the funeral diffication; Te		28d. Describe how in	njury occurred
Division of Division of Ital or Attending P Ital or Attending P Ital or Attending P Ital or Attending to the Ital or I	3 Suicide 4 Homicide  3 Suicide 4 Homicide  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street City or Town, St	and Number or Rural Route Number, ate)
Division of Vita  Division of Vita  To the Hospital or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director,  Medical Certification; To Be G	29a. Certifier  (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death and manner stated.	n occurred at the time, date a	and place, and due to the cause(s)
To T or Mith	29b. Signature and title of certifier  29c. License number  D24174	29d. 1	Date signed (Month, Day, Year)
211		Battimore	MD 21201
State Registrar	APR 2 6 2005 Bleen & Jacks		

**ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 25 per phys 8842 4-27-15 vt. State of Maryland / Department of Health and Mental Hygiene 1 1 5 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Howard Klemmer Peters III 04 20 2005 2:00p 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 1200 Ednor Rd. Silver Spring Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) Pennsylvania Date of Birth (Month, Day, Year) 05-25-1960 Months 164-44-6873 1X□M 2□F 44 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Montgomery Silver Spring 1 XYes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1200 Ednor Rd. 20905 USA 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 1 Never Married 2 Married 1 □Yes 2★ No If Yes, Give Year or Dates: 1 ☐ Yes 2 ☐xNo Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Research Scientist National Cancer Inst. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Howard Klemmer Peters Jr. Jean Krandall Malcolm Peters 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Helene C. Carlson (wife) 1200 Ednor Rd. Silver Spring MD 20905 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Chesapeake Crematory 04-21-2005 <sup>1</sup> 4 □ Donation 5 □ Other (Specify) Beltsville, MD 22. Name and Address of Facility Rapp Funeral & Cremation Service 933 Gist Ave Silver Spring MD 20910 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between

**Physician** /Medical **Examiner** 

**Physician** 

/Medical

10a State

Director

Completed by Funeral

Be

ပ

MD

Examiner

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event. Its Medical Examinar must be notified at 2008.

Baltimore, Maryland 21215-0036

y physician and st the burial-transit attending p for use as ed by the detached page 2 s s after dec. within 24 hours a

To the Funeral C

completely filled i filled

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

immediate cause (Final disease or condition resulting in death)	a. AMYOTRO  Due to (or as a conse		TERAL SC	KEROSIS		Onset and Death
Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a consu	solianna (ar)				
that initiated events resulting in death) Last	c Due to (or as a conse	equence of):				
	d					
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	23c. If yes, outcome of preging the preging the second of the pregnant at time of the preging the pregnant at time of the pregnant at time at	tal death 3 Ectopic	pregnancy (specify)		23d. Date of deliv Month	rery Day Year
Part II. Other significant conditions	contributing to death but not re	esulting in the underlyin	g cause given in Part I.		o use contribute to t	the cause of death? bably 4 Kunknown
				24a. Was an autopsy performed	prior to co death?	opsy findings available impletion of cause of
25. Was case referred to medical examiner?			26. Place of De	eath (Check only one)		
1 ☐ Yes 2 🙀 No	Hospital: 1 ☐ Inpatient 2 [	☐ ER/Outpatient 3☐	04	Home 5 ₩ Residence	6 ∏Other (Specif	fv)
27. Manner of Death  1 Natural 5 Pending 2 Accident investigation		28b. Time of Injury M	28c. Injury at Work?	28d. Describe how in		<i>''</i>
3 ☐ Suicide 6 ☐ Could not 4 ☐ Hornicide determined		home, farm, street, fact ify)	ory, office	28f. Location (Street City or Town, Sta	and Number or Rura ate)	l Route Number,
29a. Certifier (Check only one)  Certifying P  2 Medical Exa	hysician: To the best of my kn miner: On the basis of examin and manner stated.	owledge, death occurre ation and/or investigati	ed at the time, date and plac on, in my opinion, death occ	e, and due to the cause curred at the time, date a	(s) and manner as s and place, and due to	tated. The cause(s)
29b. Signature and title of certifier	andler, h		9c. License number	7 29d. [	Date signed (Month,	Day, Year)
20 Name and address of access when						

Registrar

3

State

31. Date filed (Month)

Raul Mandler 2150 Pennsylvania Ave Ste 7404 Washington DC 20037

32. Paristrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

	•	For State Registrar	State of Maryland		artment rtificate			and M		giene ()	)5	14110
Dhusiaia		1. Decedent's Name (First, Middle,	Last)						2. Date of Dea Month	ith Day	Year	3. Time of Death
Physicia /Medica		Mary	Bernice	Proct					April :	17, 200	5	12:40AM M
Examine	er	4a. Facility Name (If not institution,			4b. City,		Location o			4c. County		
	Щ	Millinium Healt  5. Social Security Number	th and Rehab.  3. Sex 7. Age (In yrs. I.	act hirthday)	If Under		Wash					George's
Funeral Director		219-26-1668	1□M 20 F 87	Yrs.	Months	Days	Hours	Min.	8. Date of Birth (Month, Day July 1	1917	Ma	oryland
		Usual Residence of Decedent										
arylan show	_	10a. State 10b. County		/, Town or Lo								10d. Inside City Limits
the Ma 28e-f s	Director	Maryland Prince	George's	Fort	-		n					1 ☐ Yes 2 ☐XNo
uth with the Maryla 23e or 28e-f sho		10e. Street and Number 12021 Livingsto	on Road		10f. Zip 20	744				10g. Citizen of U.S		intry?
er dez	by Funerai	11. Marital Status  1 □ Never Married 2 □ Marrie 3 ☑ Widowed 4 □ Divorced	12. Was Decedent Ever in U.: Armed Forces? 1 _Yes _ 2M No If Yes, Give Year or Dates:	1	Was Deced f Yes, spec 1 ☐ Yes 2		spanic Origin, Mexican Specify:	gin? (Spe n, Puerto I	ecify Yes or No- Rican, etc.)	14. Rad Bla Specif	ck, White	ican Indian, , etc. lite
215-0 nin 72 ho n. "natur Medical	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)		16a. Deced (Give life.	dent's Usua kind of wor DO NOT us	l Occupa k done d e retired)	tion uring mosi	t of workii	ng	16b. Kind of B		ndustry
212 od witt er the	Com	8th		Homem	aker					Нот		
	To Be (	17. Father's Name (First, Middle, L Frederick Mars	,						( <i>First, Middl</i> e, ine Virg		,	or
		19a. Informant's Name/Relationshi				•			Route Numbe			·
		20a. Method of Disposition 1 □ Burial 2 □ Cremation		lace of Dispo emetery, crer	sition (Nam	e of her place	a)   I	-	late 23,	20c. Location		
Pages tment of tent: if ite		* 4 ☐Donation / 6 ☐ Other (Sp.	ecity) Res	urrect				2005				Maryland
Baltimo permit. Page Department of importent: if any injury or gene.		21. Signature of Funeral Service	M362						Funera Ferry			m, MD20735
Physician		3a. Part1. Enter the diseas of shock, or heart failure. If to immediate Cause (Findisease or condition	omplications that caused the deathinly one cause on each line.						or respiratory ar			Approximate Interval Between Onset and Death
/Medical Examiner private personner in the burial-transit	dical Examiner	resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of the consequence o	uence of): uence of):								
(D = = 0	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregna 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de 9 □ Unknown	death 3	Ectopic pro			.,			ite of delik	very Day Year
dS, P.	þ	Part II. Other significant condition	ns contributing to death but not resu	ulting in the u	nderlying ca	iuse give	n in Part I.		23e. Did to			the cause of death?
of Vital Records, Physicien: The law requires th this certilicate has been signe ral director, page 2 should be c	Completed								24a. Was autop	med?	prior to codeath?	opsy findings available ompletion of cause of
f Vital Re	e Co	25. Was case referred to medical					00.5:	-45	1 ☐ Yes	21-No	1 🗆 Yes	2 No
Vit sicies certi	o Be	examiner?	Hospital: 1 Inpatient 2	ER/Outpatier	nt 3 DO	Othe			n <i>(Check only o</i> me 5□ Resid		or /Snec	rhe)
on of ding Phy h. After this funeral d	$\vdash$	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury		Bc. Injury Work	at	1	28d. Describe h			··y)
Division or Attending after death. Director: After	Certification:	3 Suicide 6 Could not determine	ot be OR - Bless of Injury At he	ome, farm, str	reet, factory	, office			28f. Location (S City or Tow		ber or Rui	ral Route Number,
Division O  To the Hospitel or Attending Puwithin 24 hours after death.  To the Funerel Director: After the completely filled in by the funeral	edical C		Physician: To the best of my know xaminer: On the basis of examinal and manner stated.									
To the within To the complex c	Me	29b. Signature and title of certifier	lan		290	License (	number	65	:	29d. Date signe		Day, Year)
\		· ·	no completed cause of death (Item									
		Michael G. Sida	arais, M.D. 1170	1 Livi	ngsto	n Ro	ad #1	LO1 F	Fort Was	shington	n MD	20744
Star Registra		31. Date filed (Month, Oay, Year)	R 2 6 2005	فر مع	A SAN	sale.						

DHMH 17 Rev 1/2001

1 - For Stete Registrar

eatine Pearne within 24 hours a To the Funerel C

this

Physician/Medical 23d. Date of delivery Year Month Day Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ SINO 1 🗌 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other 2 1 Tyes No 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) Manner of Seath 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification; Natural Accident 5 Pending investigation М 1 ☐ Yes 2 ☐ No 6 Could not be 3 C Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mainten as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) callse of death (Item 23a) (Type, Print)

300 West 9th Street, Frederick, MD 21701

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene |

Certificate of Death

Reg. No.

3. Time of Death

Birthplace (State or Foreign Country)

10d. Inside City Limits

Approximate Interval Between Onset and Death

1XYes 2 □ No

Maryland

White

Black, White, etc.

Schmidt

3:15 PM

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

32. Registrar's Signature

APR 2 6 2005

Robert Kaufmann

			For State Registrar	State of M	aryland		irtment of I		ind Mer	ntal Hy	ygie Reg.	- L U 1	05	14	112
			Decedent's Name (First, Middle, Last	)	-					Date of D	eath			3. Time	of Death
	Physicia		Duane Lester Pat	terson						Month pril		Day 2005	Year	1:45	рм М
100	/Medic Examin		4a. Facility Name (If not institution, give		)		4b. City, Town,	or Location of				4c. County	of Death	1 = 1	
		Ŭ.	10504 Montrose A	venue #2			Bethes	da				Mont	gome	сy	
	Funeral		5. Social Security Number 6. Se		ge (In yrs. lasi	t birthday)	If Under 1 Year Months Days			Date of B (Month, D	irth Dav. Ye	ar)	9. Birthp	lace (State	or Foreign
	Director		276-24-3633	Ď.M 2□F	77	Yrs.			J	an. 2	26,	1928		nío	
	p ,		Usual Residence of Decedent  10a. State 10b. County		10c. City, T	Fown or Lo	cation						1	0d. Inside	City Limits
	ahor	5		0.7477	,	nesda									s 2 No
	he N	Director	Maryland Montgon  10e. Street and Number	iery	Deti	lesua	10f. Zip Code				10g	Citizen of W	/hat Cour	ntry?	·
	a or	급	10504 Montrose Av				2081	/.				Jnited		•	
	eath	Funeral	11. Marital Status	12. Was Decedent	Ever in U.S.	13. \	Vas Decedent of	Hispanic Orig	in? (Specify	Yes or N	_			an Indian,	
	Harr Iner	Fun	1 Never Married 2 Married	Armed Forces	?	1	Yes, specify Cut	ban, Mexican,	, Puerto Rica	an, etc.)			k, White,		
200	urs a	ρ	3 \( \overline{M}\) Widowed 4 \( \overline{M}\) Divorced	If Yes, Give Year or Dates:			I□Yes 2ሺ No	Specify:				Specify.	Wh	nite	
Š	filed within 72 hours after death with the Maryland Hygiene. Wher than "natural", or Itama 23s or 28s-f ahow ent, its Medical Examiner must be notified at	Completed	15. Decedent's Edu (Specify only highest grad		1	16a. Deced	lent's Usual Occu	ipation	of working		16b	. Kind of Bu	siness/Inc	dustry	
2	hin 7 8. Med	ple	Elementary/Secondary (0-12)	College (1-4or	5+)	life. I	DO NOT use retire	ed)	or working						
2	or th	Con		4		U	nderwrit						ranc	e	
2	al Hy a oth	Be (	17. Father's Name (First, Middle, Last)					18. Mother	r's Name (F	irst, Middl	e, Mai	den Sumam	θ)		
<u>yla</u>	Ment Ment arkac	္	Lester Patterson						borah						
a	2 should be filed within 72 hours after death with the Marylan and Meantal Hygiens is marked other than "natural", or Itama 23e or 28e-f show is marked other than "natural", or Itama to notified at aumatic avent, the Medical Examiner mast he notified at		19a. Informant's Name/Relationship (T				g Address (Stree								6005
2	s 1 and 2 should of Health and Men Item 27 is marks other traumatic		Deborah A. Casill	o/Niece			omlinson sition (Name of				-	FLOT:			-6305
0	Pages 1 nent of H nnt: If ite ury or oti		20a. Method of Disposition 1 □ Burial 2 X Cremation 3 □	Removal from State	cem	etery, cren	natory or other pla	ace) [A]	prilate	22,					
	tent:		' 4 □ Donation 5 □ Other (Specify,		Cı		gomery I		2005	-	Be	ethesd	a, M	aryıa	na
Baltimore, Maryland 21215-0036	permit. Pages of Department of the importent: If its any injury or of once.		21. Signature of Funeral Service Licen	Town	MO1420	Ro	Name and Addr bert A. P 57 Wiscon	umphrey	Funera	al Hom	ne/Be	ethesda- Maryland	-Chevy 1 208	7 Chase 14	e, Inc.
П			23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	lications that cause one cause on each	ed the death. line.	Do not ent	er the mode of dy	ing, such as	cardiac or re	espiratory	arrest,			Approxim Interval B	etween
,	Physician		Immediate Cause (Final disease or condition	AS.	< V	10						/	1	Onset and	Death
	/Medical		resulting in death)	Due to (or as	s a consequer	nce of):						Ó		2)	
Р	Examiner			b				100							
1/	Sit 3d	Examiner	cause. Enter Underlying Cause (Disease or injury	Due to for as	s a consquer	nce off:							1		
V	and and I-tran	хап	that initiated events resulting in death) Last	c. Due to (or as	s a consequer	nce of):									
8760,	cate be executed oblysician and the burial-transit	ai E	Line 4												
687	phys phys s the	dicai		d											
	The law requires that the death certific Ite has been signed by the attending p page 2 should be detached for use as	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome								23d. Date	e of delive	ery	
Box	atter I for u	ciar	in the past 12 months?	1□Live birth 4□Pregnant a			Ectopic pregnant Other <i>(specify)</i>					Mor		Day	Year
o.	that the de led by the a detached	ysi	9 Unknown	9□ Unknown											
م	uires that signed b d be deta	y P	Part II. Other significant conditions co	ontributing to death	but not resulti	ng in the u	nderlying cause g	even in Part I.		23e. Dio	tobac	co use contr	ibute to th	ne cause o	death?
rds	quire n sig	d be								1 🗆	] Yes	2 🗆 No	3 Prob	ably 4 X	Unknown
00	s been si should	Completed								24a. Wa		24b. V	Vere auto	psy finding	s available cause of
Be	The lay	mo								per 1 Yes	opsy formed 2	1? d	leath?		cause or
tal	ician: The certificate rector, pag	a	25. Was case referred to medical					26. Place	of Death (C			140			
>	yaici s cer direct	To B	examiner? 1 X Yes 2 □ No	Hospital: 1   Inpat	tient 2 🗆 EF	NOutpatier	it 3□ DOA O	lthor	rsing Home			e 6 🗆 Othe	ar (Specif	y)	
ō	Attending Phyaician: r death. ector: After this certific: by the funeral director, i		27. Manner of Death	28a. Date of Inj	jury 21	8b. Time o	28c. Inj	ury at	28d	f. Describe	e how i	injury occurr	ed		
ō	ath. r: Aff	atio	1, Natural 5 ☐ Pending 2 ☐ Accident investigation		, , , , ,	,=//		Yes 2 1	No						
Division of Vital Records,	l or Attending I after death. Director: After I in by the funer	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Ir building, e	njury - At hometc. (Specify)	e, farm, str	eet, factory, office	Ð	28f.	City or T		t and Numb tate)	er or Rura	il Route Nu	mber,
_	To the Hospital or Attending Physician: The la within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	edical Ce	(Check only 2 Medical Exam	ysician: To the bes	of examination										(s)
	the hin 24	Med	one)	and manner s	stated.		20a Licer	nse number			204	Date signed	1 (Month	Day Vaar	
	To To	-	29b. Signature and title of certifier		ha: a	2			<u></u>		دعر. چام	Date signed	, anonui,	A	05
7			30. Name and address of person who	MEX-	( w)	BIE		772	10	A p.	H	PY	15		
	10		30. Name and address of person who	completed cause of	death (Item 2	3a) (Type,	Print) 2/0/	sve.	41 Ca	1 0	11	209	- 1		
			31. Date filed (Month, Day, Year)	32 Ranis	trar's Sonatu	ге	Ji (UP	pr	17	sn!	)	100	0 2		
	Regist	ate rar	APR	2 6 2095	Lilvan	en s	Print) 2101 Silve	the same							

		<ol> <li>Decedent's Name (First, Middle</li> </ol>	le, Last)								2. Date of De Month	ath Day	Yea	3. Time	f Death
Physiciar /Medica		Dorothy		M	lay		Pro	utt			April	13	2005		0 ^
Examine		4a. Facility Name (If not institution	n, give street	and number	r)		4b. City, T	own, or	Location	of Death		4c. Co	ounty of De		
		Anne Arundel	l Medic	cal Ce	nter			napo				A	nne A	rundel	
ıneral		5. Social Security Number	6. Sex 1 ☐ M 2			last birthday,	) If Under 1 Months	Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da Jan. 2	th y, Year)	9. 8	Birthplace (State Country)	or Foreig
ctor		219-30-4040	10 161 2	X'	82	Yrs.					Jan. 2	5,192	3 M	laryland	
	-	Usual Residence of Decedent  10a. State 10b. County	/		10c. City	y, Town or L	ocation							10d. Inside	ity Limit
a Dod	0	MD Anne	e Arund	101		Gambri	1110							1 ☐ Ye	2 💢 N
olical Executer rotal be notified at	Director	10e. Street and Number	Alune	4CT		<u> Саш</u> БГ	10f. Zip (	Code				10g. Citize	n of What	Country?	
		201 Comonday T	D-1-4 T					21	054			U	SA		
	Funerai	201 Serenity I 11. Marital Status	12. W	as Deceden	t Ever in U.	S. 13.	Was Decede			gin? (Sp	ecify Yes or No Rican, etc.)		Race - A	mencan Indian,	
i	큔	1 ☐ Never Married 2 ☐ Mar	rried 1	med Forces □Yes 2X Yes, Give			1 Yes 2		Specify:		Rican, etc.)		Black, W		
1	py	3 Widowed 4 Divorced	d Ÿe	ear or Dates	: 150		1 0 105 2	as INO	эрвспу.			3	Specify: White		
	ompleted	15. Deceder (Specify only highe	nt's Education			(Give	edent's Usual e kind of work	k done a	luring mos	t of work	of working 16b. Kind of Business/Industry				
a Pic	dr.	Elementary/Secondary (0-12)	C	ollege (1-40)	r 5+)		DO NOT use	e retired	)						
	0	12 17. Father's Name (First, Middle,	( act)			_Home	emaker	1	19 Mark	arie Nine	First Middle		n Hom	e	
	ă										Name (First, Middle, Maiden Sumame) cace Stuckett				
T P	္ ရ	Raymond B. Chaney Gra									100.0		Canal	- Tip Codel	
permit. Pages 1 and 2 should be filed within 72 he besecuted by S. Department of Health and Mental Hygiene.  Department of Health and Mental Hygiene.  Important: If item 27 is marked other then "nature buriat-transit or other traumatic event, its Medical pages."  To Re Committeed.															
		20a. Method of Disposition	L (no	isbanu		_					Date Gam			or Town, State	
		1 Burial 2 Cremation		al from State	e		osition (Name ematory or oth								
		<ul><li>4 □ Donation 5 □ Other (\$21. Signature of Funeral Service</li></ul>			H1.		St Ceme			STATE OF THE PARTY	-2005	Anna	polis	, MD	
		178- 9.1	4	-			Harde	20 + 37	Fune	eral	Home,	P.A.			
		23a. Part1. Enter the disease, o shock, or heart failure. Lis Immediate Cause (Final	or complication t only one cau	use on each	line.	n. Do not en	12 Ri	idge	ly Ay	renue	Anna Anna	polis	, MD	21401 Approxima Interval Be Onset and	tween
ner ligness	ŭ	shock, or heart failure. Lis-	a b c	Due to (or a	is a consequence a consequence	uence f):	12 Ri	idge	ly Ay	renue	Anna Anna	polis	MD	Approxima Interval Be	tween
ical iner as the burial-transit	edicai Ex	shock, or heart failure. Lis Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or many that initiated events	a b c 23c. If	Due to (or a	is a consequence of pregna 2 Fetal at time of de	uence of): uence of): uence of):	12 Ri	egnancy	ly Ay	renue	e, Anna	polis rrest,	d. Date of o	Approximinterval Be Onset and	Year
ical iner	by Physician/Medical Ex	shock, or heart failure. Lis Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or right) that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 — Yes 2 — NOT	a b c 23c. If 11 4 9	Due to (or a  Due to (or a  Due to (or a  Ves, outcom Cive birth Pregnant Unknown	is a consequence of pregna 2 Fetal at time of de	uence of):  uence of):  uence of):  uence of):	12 Rinter the mode	idge of dying	1y Ay g, such as	cardiac (	e, Anna or respiratory a	polis rrest,	d. Date of o Month	Approximination in the cause of the cause of	Year death?
should be detached for use as the burial-transit	ompleted by Physician/Medical Ex	shock, or heart failure. Lis Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 Hoo	a b c 23c. If 11 4 9	Due to (or a  Due to (or a  Due to (or a  Ves, outcom Cive birth Pregnant Unknown	is a consequence of pregna 2 Fetal at time of de	uence of):  uence of):  uence of):  uence of):	12 Rinter the mode	idge of dying	1y Ay g, such as	cardiac (	23e. Did 1  24a. Was auto	polis urrest,  23  tobacco use Yes 2  an	d. Date of Month  contribute  No 34  24b. Were prior to death	Approximinatorial Balance and Conset and Con	Year  death?  Unknow
2 should be detached for use as the burial-transit	by Physician/Medical Ex	shock, or heart failure. Lis Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 Hoo	a b c 23c. If 11 4 9! ions contribut	Due to (or a  Due to (or a  Due to (or a  Que to (or a	is a consequence of pregna 2 Fetal at time of de	uence of):  uence of):  uence of):  uence of):	12 Rinter the mode	egnancy ecity)	1y Ay g, such as Par an in Part	cardiac (	23e. Did 1  24a. Was auto	tobacco use Yes 2  is an psy psy psy psy 2 No	d. Date of Month  contribute  No 34  24b. Were prior to death	Approximination interval Be Onset and Onset an	Year Unknow
al director, page 2 should be detached for use as the burial-transit	To Be Completed by Physician/Medical Ex	shock, or heart failure. Lis Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	a b c 23c. If 1   4   9   ions contribut	Due to (or a  Due to (or a  Due to (or a  Due to (or a  Ves, outcom Live birth Pregnant Unknown  ting to death	is a consequence of pregna 2 Fetal at time of delibert not resulting tient 2	uence of):  ER/Outpatie	12 Rinter the mode	egnancy crify)	26. Place	cardiac (	23e. Did 1 24a. Was auto perfet 1 Yes. h (Check only)	tobacco use Yes 2    san psy primed? 2   No one) idence 6 [	d. Date of of Month  e contribute  No 3/2  24b. Were prior of death 1  Y	Approximinatory lateral Biogeometric Conset and Conset and Conset and Conset and Conset and Conset autopsy finding to completion of the Conset and Conset	Year  Unknow
call unection, page & should be detached for use as the burnar-unish	To Be Completed by Physician/Medical Ex	shock, or heart failure. Lis Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Underlying Und	a b c d 23c. If 1	Due to (or a  Due to (or a  Due to (or a  Due to (or a  Ves, outcom Live birth Pregnant Unknown  Unknown	is a consequence of pregna 2 Fetal at time of delibert not resulting tient 2	uence of):  uence of):  uence of):  uence of):  uence of):  uuence of):  uuence of):  uuence of):  uuence of):  uuence of):  uuence of):	The results of the mode continued and the mod	egnancy socify)  a Other	26. Place	cardiac of the cardia	23e. Did	tobacco use Yes 2    san psy primed? 2   No one) idence 6 [	d. Date of of Month  e contribute  No 3/2  24b. Were prior of death 1  Y	Approximinatory lateral Biogeometric Conset and Conset and Conset and Conset and Conset and Conset autopsy finding to completion of the Conset and Conset	Year  Unknow
aler	To Be Completed by Physician/Medical Ex	shock, or heart failure. Lis Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	a	Due to (or a  Due to (or a  Due to (or a  Due to (or a  Que to (or a	is a consequence of pregna 2 Fetal at time of definition to trest tient 2 jury	uence of):  ER/Outpatie 28b. Time of Injury	The results of the mode continues of the mode continues of the continues o	egnancy ecity)  A Other Work	26. Place	cardiac of the cardia	23e. Did 1 24a. Was auto perfit 1 yes th (Check only wime 5 Resi 28d. Describe	tobacco use Yes 2  an psy ormed? 22 No one) idence 6 [how injury of the control o	d. Date of Month  e contribute  No 3/2  24b. Were prior i death 1  Y	Approximination interval Book Onset and Onset	Year  death?  Unknow  availab cause of
aler	To Be Completed by Physician/Medical Ex	shock, or heart failure. Lis Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	a	Due to (or a  Due to (or a  Due to (or a  Due to (or a  Ves, outcom Live birth Pregnant Unknown  ting to death  tal: Inpa  tal: Inpa  tal: Replace of I	is a consequence of pregna 2 Fetal at time of definition to trest tient 2 jury	uence of):  uence	The results of the mode continued and the mod	egnancy ecity)  A Other Work	26. Place	cardiac of the cardia	23e. Did 1 1 24a. Was auto perfu 1 Yes th /Check only one 28f. Location (	tobacco use Yes 2  an psy ormed? 22 No one) idence 6 [how injury of the control o	d. Date of Month  e contribute  No 3/2  24b. Were prior i death 1  Y	Approximinatory lateral Biogeometric Conset and Conset and Conset and Conset and Conset and Conset autopsy finding to completion of the Conset and Conset	Year  death?  Unknow  availab cause of
Calleria ottector, page & stronto de detactieu tot use as ins buttar unation.	Certification: To Be Completed by Physician/Medical Ex	shock, or heart failure. Lis Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	a	Due to (or a  Ves, outcom  Complete of the complete of	is a consequence of pregna 2 Fetal at time of distant time of distant pury 'At home of examina st of my kno of examina	uence of):  uence	12 Rinter the mode ponia	egnancy scify)  A Other Worth  Control of the time of	26. Place 26. Place 27. 4 \( \text{Ni} \) 28. Yes 2	cardiac of the cardia	23e. Did 1	tobacco use Yes 2   an propriet and propriet and fundament of [ how injury of of [ how injur	d. Date of of Month  contribute  No 3.2  24b. Were prior ideath 1 1 Y	Approximinatorial Biological Approximinatorial Biological Biologic	Year  death?  Unknow  availab gause of
Call Innerial ottector, page & should be detached to use as the build-training	To Be Completed by Physician/Medical Ex	shock, or heart failure. Lis Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or minery that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	a	Due to (or a  Ves, outcom Cive birth Pregnant Unknown  ting to death  tal: Inpa  ta. Date of In (Month, D  building, or	is a consequence of pregna 2 Fetal at time of distant time of distant pury 'At home of examina st of my kno of examina	uence of):  uence	12 Rinter the mode Nonia    Carlot   Carlot	egnancy scify)  ause give  A Other work  for office  at the tirr in my or	26. Place 26. Place 27. 4 \( \text{No.} \) 27. 4 \( \text{No.} \) 28. Place 37. 4 \( \text{No.} \) 29. Place 39. 4 \( \text{No.} \) 30. Place 30. Alternative and a point on, dead	cardiac of cardiac of the cardiac of	23e. Did 1 1 24a. Was auto perfet 11 Yes The Check only one 5 Resi 28d. Describe 28f. Location (City or To and due to the red at the time,	tobacco use Yes 2    an psy press yes 2    an psy press idence 6 [ how injury of wn, State)  cause(s) at date and p  29d. Date	d. Date of a Month  e contribute  No 3/2  24b. Were prior of death 1 1 Y  Other (S)  Coccurred  Number or	Approximinatorial Biological Approximinatorial Biological Approximation and the cause of Probably 4 Day autopsy finding to completion of 12 Probably 4 Day P	Year  death?  Unknown  available cause of
oletely filled in by the funeral director, page 2 should be detached for use as the burial-transit	edical Certification: To Be Completed by Physician/Medical Ex	shock, or heart failure. Lis Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or minery that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	a	Due to (or a  Ves, outcom  Complete of the complete of	is a consequence of pregna 2 Fetal at time of distant time of distant pury 'At home of examina st of my kno of examina	uence of):  uence	12 Rinter the mode Nonia    Carlot   Carlot	egnancy scify)  ause give  A Other work  for office  at the tirr in my or	26. Place 26. Place 27. 4 \( \text{No.} \) 27. 4 \( \text{No.} \) 28. Place 37. 4 \( \text{No.} \) 29. Place 39. 4 \( \text{No.} \) 30. Place 30. Alternative and a point on, dead	cardiac of cardiac of the cardiac of	23e. Did 1 1 24a. Was auto perfet 11 Yes The Check only one 5 Resi 28d. Describe 28f. Location (City or To and due to the red at the time,	tobacco use Yes 2    an psy press yes 2    an psy press idence 6 [ how injury of wn, State)  cause(s) at date and p  29d. Date	d. Date of a Month  e contribute  No 3/2  24b. Were prior of death 1 1 Y  Other (S)  Coccurred  Number or	Approximination and interval Brown and Conset and Conse	Year  death?  Unknown  available cause of

		1 - State Registrar		aryland / Dep Ce	ertificate c		R	leg. No	5 1411
Physici: /Medic	cal		PusseLL		Ab Cib. Tour	n, or Location of Dea	2. Date of Dea	Day_ Ye	3. Time of Death
Examin Funeral Director	ier	4a. Facility Name (If not institution, given 15109 Dover 5. Social Security Number 6. S 217–40–2479	Rd.	ge (In yrs. last birthda) 63 Yrs.	Re	isterstow	n s. 8. Date of Birth	Bal 9.	timore  Birthplace (State or Forei Country)  Maryland
D	tor	Usuel Residence of Decedent  10a. State  10b. County  Md. Baltimo	re	10c. City, Town or Reiste:					10d. Inside City Limi
ih with the 23a or 28a	Funeral Director	10e. Street and Number 15109 Dov	er Rd.		10f. Zip Cod 211			10g. Citizen of Wha	t Country?
72 hours after death with the Maryland naturel', or Iteme 23a or 28a-f ehow dicel Examiner must be notified at	þ	11. Marital Status  1   Never Married 2   Married  3   Widowed 4   Divorced	12. Was Decedent Armed Forces?  1  Yes 2 1 If Yes, Give Year or Dates:	?	Was Decedent of If Yes, specify 0	of Hispanic Origin? ( cuban, Mexican, Pue No Specify:	Specify Yes or No- rto Rican, etc.)		American Indian, White, etc. White
within ne.	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)	ducation ade completed) College (1-4or	(Giv	edent's Usual Oc re kind of work do DO NOT use rei Board C	ne during most of wo tired)	orking	16b. Kind of Busin	
should be filed and Mental Hygie marked other tameric event, in	To Be C	17. Father's Name (First, Middle, Last, James Benning	Russell	105 146	ilin a Antonom (Car		s Evelyn	Kieffer	to Zia Coda)
permit. Pages 1 and 2 should Department of Health and Mer Important: If item 27 is marke any injury or other traumatic once.		19a. Informant's Name/Relationship ( Rabeth Cooper =  20a. Method of Disposition 1  Burial 2  Cremation 3  4  Donation 5  Other (Specifications) 21. Signature of Furieral Service Licer	Removal from State	20b. Place of Disposemetery, or Metro C	5 Dover	Rd., Reis	Date 25, 2005	Md. 211 20c. Location - City Baltimo	or Town, State
Physician /Medical Examiner	cal Examiner	disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as	a consequence of):  a consequence of):  a consequence of):		4-11,011	7 01327	732	Toylan
ne death certificate the attending phy: thed for use as the	Physiclan/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	23c. If yes, outcome 1 Live birth 4 Pregnant a	2 Fetal death 3	□Ectopic pregna □ Other (specify			23d. Date of Month	delivery Day Year
quires that the signed by all be detact	by	Part II. Other significant conditions of	contributing to death t	out not resulting in the	underlying cause	given in Part I.			te to the cause of death?  Probably 4 Unkno
The law requires that sate has been signed b page 2 should be deta	Completed						24a. Was a autops perform	in 24b. Wer sy prior med? deat 2 X No 1	
Physician: The this certificate ral director, pag	To Be	25. Was case referred to medical examiner?  12 Yes 2 No	Hospital: 1 ☐ Inpati	ent 2 ER/Outpati	ent 3 DOA	26. Place of De Other: 4 Nursing	eath (Check only on Home 5 Reside	ne) ence 6 □Other (	Specify)
tending leath. tor: After the fune	ertification:	27. Manner of Death  1 Natural 5 Pending 2 Accident investigatio 3 Suicide 6 Could not be	e 290 Plane of In	ury 28b. Time ay Year) 2njury Injury - At home, farm, s	M 1	njury at Work?   Yes 2 No		ow injury occurred	r Rural Route Number,
To the Hospitet or Attent within 24 hours after death to the Funeral Director: completely filled in by the	O	4 Homicide determined  29a. Certifier 1 Certifying Ph	building, e	tc. (Specify) of my knowledge, dea	ath occurred at the	e time, date and place	City or Town	n, State)  ause(s) and manne	r as stated.
To the Ho within 24 to to the Fu completely	Medical	(Check only 2 Medical Example)  29b. Signature and title of certifier	niner: On the basis of and manner st		29c. Lice	ense number	2	9d. Date signed (M	
11		Le Kill Prival	MAN	10 to 1	101	8/17		Annil 2	3,2005 ud 21093

				epartment of Health and Mental Certificate of Death	Hygiene					
	Physici	an	1. Decedent's Name (First, Middle, Last)	2. Date	of Death 3. Time of Death					
	/Medic	cal	Loseph Kose	Figur	11 23 2005 /115 PM					
	Examir	ier	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death  Souffinous	4c. County of Deeth N/A					
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birtho		of Birth 9. Birthplace (State or Foreign					
	Director		317-76-3701 12- 20F 55 Yr	s. Months Days Hours Min. (Mon Jul	th, Day, Year)  Y 16,1949   Tennessee					
	and		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town of the County 10c. City, Tow	or Location	10d. Inside City Limits					
	Maryl 1 sho	ō			1 ⊠ Yes 2 ☐ No					
	r 28a	Funeral Director	Maryland N/A  10e. Street and Number	Baltimore City 10f. Zip Code	10g. Citizen of What Country?					
	th with	ai D	1621 McHenry Street	21223	United States					
	tems er m	ner	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	<ol> <li>Was Decedent of Hispanic Origin? (Specify Yes If Yes, specify Cuban, Mexican, Puerto Rican, et</li> </ol>	or No- 14. Race - American Indian, c.) Black, White, etc.					
36	72 hours after death with the Maryland natural', or items 23a or 28a-1 show dical Examinat must be rodified at	by Fu	1 TyNever Married 2 Married 1 Mes 2 TyNe If Yes, Give 3 Widowed 4 Divorced Year or Dates:	1 ☐ Yes 2 📆 No Specify:	Specify:					
5-0036	2 hou stural	ted t	15. Decedent's Education 16a. D	ecedent's Usual Occupation	White  16b. Kind of Business/Industry					
215	within 7. lene. than "n	Completed	(Specify only highest grade completed) ((Specify only highest grade completed) ((Specify only highest grade completed)	Give kind of work done during most of working fe. DO NOT use retired)	nost of working					
2121	filed wii Hygien other th	Con	6 Years	Disabled	N/A					
Maryland	d la d	Be	17. Father's Name ( <i>First, Middle, Last</i> )  Fielden Rose	18. Mother's Name (First, M						
Ž	should nd Men marke umatic	2		Gladys Shep    Gladys Shep						
	1 and 2 s Health ar sem 27 is other trau			21 McHenry Street Balt						
ore,	ges 1 and 3 of Health if Item 27 or other tr		20a. Method of Disposition  1 Burial 2 Scremation 3 Removal from State	isposition (Name of Date crematory or other place)	20c. Location - City or Town, State					
Ĕ	Pages ment of I ant: If It		4 Donation 5 Dother (Specify)	pp Service Corp. 4/25/20	05 Towson, Maryland					
Baltimore,	permit. Pag Department Important: i any injury o 2002e.		21. Signature of Furreral Service Louise	22. Name and Address of Facility Duda-Ruck Funeral Home 7922 Wise Ave. Dundalk						
			23a. Part . Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.	enter the mode of dying, such as cardiac or respiral	tory arrest, Approximate Interval Between					
	Pnysician		Immediate Cause (Final disease or condition	Lage Kennel Discus	Onset and Death					
	/Medical Examiner		resulting in death)  Due to (or as a consequence of)							
		e	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury							
1	uted d ansit	Examiner	cause. Enter Underrying Cause (Disease or injury that initiated events  c.							
0	sate be executed obysicien and the burial-transit		resulting in death) Last Due to (or as a consequence of)							
8760,	cate by physic the bu	dical	d							
9 xo	The law requires that the death certificate be executed the has been signed by the attending physicien and age 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23c. If yes, outcome of pregnancy	4000 - 4100 (MON)	22d Date of deliver.					
B	death a atter d for u	iciar	in the past 12 months?    Use birth   2 Fetal death   1 Yes   2 No   4 Pregnant at time of death	3 □Ectopic pregnancy 5 □ Other (specify)	23d. Date of delivery  Month Day Year					
P.0	t the de by the a tached	hys	9 Unknown 9 Unknown							
	es tha igned be det	by P	Part II. Other significant conditions contributing to death but not resulting in the	e underlying cause given in Part I. 23e.	Did tobacco use contribute to the cause of death?					
ord	w requir been si should	sted			1 Yes 2 No 3 Probably 4 Unknown					
Records,	e law has b	Completed		24a.	Was an autopsy findings available prior to completion of cause of death?					
a		e Co	25. Was sees referred to medical	101	Yes 2 No 1 Yes 2 No					
Vital	Physician: This certificeral director, p	o Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☑ No  Hospital: 1 ☑ Impatient 2 ☐ EP/Outp.	26. Place of Death Check	on one Residence 6 □Other (Specify)					
J of		T iu	27. Manner of Death 28a. Date of Injury 28b. Tim	e of 28c. injury at 28d. Desc	cribe how injury occurred					
ioi	Attending I r death. sctor; After by the funer	atio	2 Accident investigation	M 1 Yes 2 No						
Division	in the	Certification;	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury - At home, farm building, etc. (Specify)		tion (Street and Number or Rural Route Number, or Town, State)					
	수 교 교 등	edical C	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, dead of the basis of examination and/or and manner stated.	eath occurred at the time, date and place, and due to r investigation, in my opinion, death occurred at the	o the cause(s) and manner as stated. time, date and place, and due to the cause(s)					
	To the I within 2. To the I complet	Me	29b. Signature and title of contribution with the pass of person who completed cause of death (Item 23a) (Type 131. Date filed (Month, Day, Year)  1. Certifying Physician: To the best of my knowledge, of the pass of person who completed cause of death (Item 23a) (Type 131. Date filed (Month, Day, Year)  29b. Signature and title of contribution with the pass of person who completed cause of death (Item 23a) (Type 131. Date filed (Month, Day, Year)  32. Registrats Signature	29c. License number 10052950	29d. Date signed (Month, Day, Year)  April 33, 2005					
	2		30. Name and address of person who completed cause of death (Item 23a) (Ty	pe, Print) Hy Hymnine MIT)	21723					
	Sta	te	31. Date filed (Month, Day, Year)  32. Registras Signature	perionois 110	<i></i>					
	Registr	_	APR 2 6 2005 Mayer &	e sparle						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			For State Registrar		epartment of Health and Certificate of Death	Mental Hygier	71115	14116
	Physici		1. Decedent's Name (First, Middle, Last)	ROSOER		2, Date of Death Month	Day Yeer	3. Time of Death
	/Medio Examin		4a. Facility Name (If not institution, give stree		4b. City, Town, or Location of Dea		4c. County of Death	
707 Dm			GILFHRUT IZOT		icuson		BALTIMO	
X	Funeral Director		5. Social Security Number 6. Sex	2□F 7. Age (In yrs. last birth	rs. If Under 1 Year If Under 24 Hr Months Days Hours Mir			nplace (State or Foreign untry)
	ъ		Usual Residence of Decedent			1001.93 19	72 11 1151	
5	show	5	10a. State 10b. County	10c. City, Town	or Location			10d. Inside City Limits 1 ☐ Yes 2 No
20	the M	recto	Madano Ballinga	TAR	10f. Zip Code	100.	Citizen of What Cou	
3	h with 23a or	a D	TROATILMONT	AVI.	21234		Q. Z. U	
4/23/0	r deat	Funeral Director	11. Marital Status	Vas Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? ( If Yes, specify Cuban, Mexican, Pue	Specify Yes or No-	14. Race - Amer Black, White	
98	be filed within 72 hours efter death with the Marylend atal Hyglene. All the Marylene, or Itame 23a or 28e-f show event, the Modical Examinar months to notified at	by Fi	1 ☐ Never Married	Yes 2 □ No Yes, Give Year or Dates:	1 ☐ Yes 2 No Specify:		Specify:	13-1-6
nied 215-0036	2 hou	ted	15. Decedent's Educatio (Specify only highest grade con	n 16a. [	Decedent's Usual Occupation	16b.	. Kind of Business/li	ndustry
anie 121215-	vithin 7	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	Give kind of work done during most of w life. DO NOT use retired)	- C	1	
9	filed w Hygle other t		17. Father's Name (First, Middle, Last)	115-	18. Mother's Na	ame (First, Middle, Maid		RPORALION
	should be nd Mental marked o	To Be	1	Os_R	71114	NARO	ini	
Marylan	and and and and		19a. Informant's Name/Relationship (Type, I		Mailing Address (Street and Number or F	Rural Route Number, Cit	y or Town, State, Zi	ip Code)
6.3	1 and 2 Health em 27 i		20a. Method of Disposition	20b Place of 1	Disposition (Name of	Date 20c.	Location - City or T	00 a1334
D	Pages nent of h nnt: if its		TS Burial 2 ☐ Cremation 3 ☐ Remo 4 ☐ Donation 5 ☐ Other (Specify)	val from State	crematory or other place)	ELAR. D	OV.	Magilia A
oede	permit. Pages 1 an Department of Heal Importent: if Item 2 any injury or other once.		21. Sign that if Funeral Service Lio nsee	1 10(5)	22. Name and Address of Facility	EMORILL	1640,177	I LAKOTEN (T)
Q "	permii Depar impol any ir		Lan Kill		SSOC HAVEORD ISC	AD PARKET	12 MARY	+160 2 Bay
			23a. Part1. Enter the disease, or complication shock, or heart failure. List only one can	use on each line.		ac or respiratory arrest,	,	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	metastatic		)	-	months
	Examiner		f .	Due to (or as a consequence of	):			
1/	, p ==	ner	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury	Due to (or as a consequence of	):			
ν	xecute and I-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of	):			
68760	The law requires that the death certificate be executed ate has been signed by the attending physicien and page 2 should be detached for use as the burial-transit		d		,			
_	rtificat ng phy s as th	Medical	IF FEMALE:					
Box	ath ce attendii for use	Physician/M	23b. Was decedent pregnant in the past 12 months?	f yes, outcome of pregnancy	3 Ectopic pregnancy		23d. Date of deliv Month	very Day Year
C	that the de led by the a detached f	ysic		I∏Pregnant at time of death I∏Unknown	5 Other (specify)			
Division of Vital Records. P.O.	s that	by Pi	Part II. Other significent conditions contribu	iting to death but not resulting in	the underlying cause given in Part I.	23e. Did tobacc	o use contribute to	the cause of death?
, de	w requires that s been signed t	ted				1 X Yes	2 No 3 Pro	bbably 4 Dunknown
Jec.	has by	Completed				24a. Was an autopsy performed	prior to co	opsy findings available ompletion of cause of
<u></u>	in: Th ificate or, pag		25. Was case referred to medical		26 Place of De	1 ☐ Yes 2 风 I eath (Check only one)		2 No
Š	iysicis iis cert direct	To Be	examiner? 1 Yes 2 No Hosp	tal: 1 Inpatient 2 ER/Outp	Othon	Home 5 ☐ Residence	6 Other (Speci	(M) Crossia
	ing Ph Viter th			Ba. Date of Injury (Month, Day Year) 28b. Ti	ury Work?	28d. Describe how in	jury occurred	
ojsi ojsi	death ctor: / y the f	ficati	2 Accident investigation 3 Suicide 6 Could not be	Be. Place of Injury - At home, farr	M 1 Tyes 2 No	28f. Location (Street	and Number or Rui	ral Route Number.
j	el or A s after st Dire	Certification;	4 Homicide determined	Be. Place of Injury - At home, fare building, etc. (Specify)	n, street, lastery, silico	City or Town, Sta	ate)	
	To the Hospitel or Attanding Physician: The i within 24 hours after death. To the Funerel Director: After this certificate ha completely filled in by the funeral director, page	edical (	(Check only 2 Medical Exeminer:	n: To the best of my knowledge, On the basis of examination and and manner stated.	death occurred at the time, date and place for investigation, in my opinion, death occ	ce, and due to the cause curred at the time, date a	(s) and manner as and place, and due	stated. to the cause(s)
	To the within 2 To the comple	Med	29b. Signature and title of certifier	<u> </u>	29c. License number		Date signed (Month,	
			> Atran	Completion	V58303	s An	211 22	5005
	13		30. Name and address of person who comple	eted cause of death (Item 23a) (T	ype, Print) WO N-Charles	St Baltu	none NO 7	1204
ei .	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signature				
	Registr	ar	APR 2 6 200	5 60 6	and the second second			

			1 - State of Marylan		artment of F			ene 005	14117
			Decedent's Name (First, Middle, Last)				2. Date of Death	1	3. Time of Death
	Physici /Medic		Vasso	Rider			Month O2+	23 200	5 00:04 AM
	Examin	er	4a. Facility Name (If not institution, give street and number) GOOD SAMALITAN HOSPITAL		4b. City, Town, o	r Location of Death		4c. County of Dea	h
ì	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. 1 M 2 17 F 80	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Dec. 3	9. Bir 7ear) 9. Bir 7. 1924 E	hplace (State or Foreign ountry) GYDt
	pu ,		Usual Residence of Decedent	T					***
	after death with the Maryland or Items 23a or 28e-f show ourser out the notified at	lor	Maryland   Baltimore   10c. Ci	ty, Town or Lo Parkv					10d. Inside City Limits 1 ☐ Yes 2 🗶 No
	r 28e-	Funeral Director	10e. Street and Number		10f. Zip Code		10	g. Citizen of What Co	ountry?
	h with	a D	1730 Yakona Road		2123	4		U.S.A.	
		ner	11. Marital Status 12. Was Decedent Ever in U Armed Forces?	.S. 13.	Was Decedent of H	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No-	14. Race - Ame Black, Whit	
36		by Fu	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒ No If Yes, Give 19 Year or Dates:		1 ☐ Yes 2 ☑ No	Specify:	,		lhite
9-0	72 hours naturel',	ted	15. Decedent's Education	16a. Deced	dent's Usual Occup	pation	1	6b. Kind of Business	Industry
215	within 7 ene. then "n	Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)			during most of world)	ang		
21	e filed within al Hygiene. I other then 'vent, Ire My	Con	12 2	Hom	e Maker		(E)	Own Ho	me
Maryland 21215-0036	s 1 and 2 should be filed within 72 hours Health and Mental Hygiene. Item 27 is marked other then "naturel", other treumetic event, Ite Mudical Ex.	To Be	17. Father's Name (First, Middle, Last)  Dimitri Paparis			Anna Anna	ne (First, Middle, M	aiden Sumame) <b>Mak</b> o	u
Man	d 2 should be h and Mental 7 is marked of treumetic ev		19a. Informant's Name/Relationship (Type, Print)  Anna Rider - Daughter		ng Address (Street Gitting			City or Town, State, 2	
	1 and 2 Health tem 27		20a Method of Disposition 20b.	Place of Dispo	sition (Name of			Oc. Location - City or	
Jou	00		1 Rurial 2 Cremation 3 Removal from State		matory or other plac emetery		25,2005		
Baltimore,	permit. Pages 1 a Department of Hea Importent: If item any injury or othe once.		21. Signature of Funeral Service Licensee	22	. Name and Addre	ss of Facility Ba	ltimore,	Maryland	
			23a. Part1. Enter the disease, or complications that caused the deal shock, or heart failure. List only one cause on each line.	th. Do not ent	eonard J.  er the mode of dyir	RUCK, II	or respiratory arre	Harford F	Approximate
	Priysician								Interval Between Onset and Death
200	/Medical		Immediate Cause (Final disease or condition resulting in death)  a. Tothe Micon Due to (or as a consecution provided in the consecution of the consecution provided in the		EKILOV.	ASCUCA	ic Heri	DEIDI	
	Examiner		Sequentially list over things		RILAT!	01			
	sit a	iner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events						
	be executed ician and burial-transit	Examine	Cause (Disease or injury that initiated events resulting in death) Last c. Due to (or as a consec		2,00				
8760,			4						
687	ficate phys	edical	0.						
Вох	eath certific attending p	In/M	IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fette		Ectopic pregnancy	ı		23d. Date of del	
	The law requires that the death certificate has been signed by the attending to the asserting to the assertion of the second of	Physiclan/M	in the past 12 months?  1 □ Yes 2 □ No 9 □ Unknown  1 □ Yes 2 □ No 9 □ Unknown		Other (specify)	,		Month	Day Year
P.O.	that the died by the detached	y Ph	Part II. Other significant conditions contributing to death but not res	sulting in the u	nderlying cause giv	en in Part I.	23e. Did toba	acco use contribute to	the cause of death?
Records,	w requires been sign should be	Completed by	ATHEROSCLEROTIC D	ISEA	SŦ		1 ☐ Yes	3 2 No 3 Pr	obably 4 Unknown
006	aw requas been 2 shoult	plet	HYPERTENSION				24a. Was an	24b. Were au	itopsy findings available completion of cause of
H		Com					perform	ed? death? XNo 1 ☐ Yes	2□ No
Vital	Physicien: The this certificate ral director, page	Bec	25. Was case referred to medical examiner?				th (Check only one		
of V	Physic this ca	2	1 ☐ Yes 25 No Hospital: 1 Minpatient 2 ☐	ER/Outpatien		4   Nursing R		nce 6 □Other (Spe	cify)
ouc	fte	tlon:	27. Marner of Death  1 Natural 5 Pending (Month, Day Year)  2 Accident investigation	28b. Time of Injury	Wor	yat k? Yes 2 □ No	28d. Describe how	v injury occurred	
Division	Attending it death. sctor: After by the fune	ifica	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At h	ome, farm, str			28f. Location (Stre	eet and Number or Ru	ıral Route Number,
Dİ	s after of Dire	Certification:	4 Homicide determined building, etc. (Special	<i>y</i> )			City or Town,	State)	
	To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu	ledical	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my known one)  2 Medical Examinar: On the basis of examinar and manner stated.	owledge, death	h occurred at the tir vestigation, in my o	me, date and place, prinion, death occur	and due to the car red at the time, da	use(s) and manner as te and place, and due	stated. to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	Ó	29c. Licens			d. Date signed (Mont	
	-		Delim Baghti MD \$		RES (			PLIL 23	2005
-	1		30. Name and address of person who completed cause of death (life)					AVEN ROU	
			SAL'M BAGHL' MD GOOD	DAM AN	KOH WHILL	STAL BAL	-INDIVE - I	11) - 212	> 7
94	Sta Regist		31. Date filed (Month Pay, Xear) 2005 32. Begistrar's Sign	Nº A	-				

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registral Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Year **Physician** 200 WILLIAM BERNARD ROLES /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death Examiner espec NORTHAUN Birthplace (State or Foreign Country) MT Date of Birth (Month, Day, Year) Kge (In vrs. last birthday) 5. Social Security Number **Funeral** Days 1**∆**M 2□F Hours MD 216-32-2379 69 Director 10/16/1935 Usuel Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ₩ No Director ANNE ARUNDEL GLEN BURNIE 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 5 21061 USA items 23a 7031 CRESTHAVEN DRIVE by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 No 196 If Yes, Give Year or Dates: 196 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 20 Married 1960-5 1 ☐ Yes 2XXXVo WHITE Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced 1964 "natural". Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 12 should be filed within 7 h and Menta! Hygiene. 7 Ia marked othar than "r Elementary/Secondary (0-12) College (1-4or 5+) PRODUCTION MANAGER MEDO INDUSTRIES 12 18. Mother's Name (First, Middle, Maiden Sumame) Maryland 17. Father's Name (First, Middle, Last) Be MARY MARIE PHILLIPS HENRY BERNARD ROLES ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) os 1 and 2 soft Health an Itam 27 la MRS. BARBARA ROLES / WIFE 7031 CRESTHAVEN DRIVE, GLEN BURNIE, MD 21061 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 NGBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Ξ ö permit. Page Department of Important: If any Injury or once. 4/25/2005 BROOKLYN, MD CEDAR HILL CEMETERY 21. Signalule of Funeral Service Lense 22. Name and Address of Facility SINGLETON FUNERAL HOME, PA 1 SECOND AVENUE SW, GLEN BURNIE, MD 21061 MO1415 23a. Part 1. Enter the disease, or complications that callsed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Pnysician acouth disease or condition resulting in death) /Medical Du to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physiclan/Medical Examiner or Attending Physician: The law requires that the death certificate be executed the burial-transit w talle Due to ( s a consequence of) Box 68760. IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day ģ in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 1 ☐ Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes funeral director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home Hospital: 1 Inpatient 1 🗌 Yes 2 ER/Outpatient 3 DOA Certification: To 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Division 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No after death. 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗌 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 | Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical

filled in by the 24 hours a completely To the within 2

> State Registrar

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

ss of person who complaind cause of death (Item 23a) (Type, Print) messo

32, Registrar's Signature

29c. License number

29d. Date signed (Month, Day, Year)

UL Del Koppin Clar President

			State of Maryland / De  State of Maryland / De  State of Maryland / De  Hegistrar amend item #1829d per phy g84  1. Decedent's Name (First, Middle, Last)	•		2. 0	Reg. I	ZUUJ	3. Time of Death
	Physicia	an		RDAN			Month 0 04 2	Year 4 2005	08:30AM
	/Medic Examin		4a. Facility Name (if not institution, give street and number)	4b. City, To	own, or Location	of Death		4c. County of Deat	
			ANNE ARUNDEL MEDICAL CENTER		POLIS	0414 1		ANNE ARUN	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda 1 1 1 M 201 7.	Months	Year If Under Days Hours	Min. (/	Date of Birth Month, Day, Yea /25/1934	ar) Co	hplace (State or Foreign untry)  VA
	Director		Usual Residence of Decedent				/ 23/ 1934	+	V11
	show	_	10a. State 10b. County 10c. City, Town or						10d. Inside City Limits 1 ☐ Yes ※XNo
	ne Ma Ba-f s	Director	MD ANNE ARUNDEL PASADEN				10-	Citizen of What Co	
	with the a or 2	Dir	10e. Street and Number 129 RITCHIE HIGHWAY	10f. Zip C			109.	USA	ound y ?
	death	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 1	3. Was Decede	nt of Hispanic Or	rigin? (Specify	Yes or No-	14. Race - Ame	
36	hours after death with the Maryland turel', or Items 23a or 28a-f show at Exertiner must be notilised at	by Fur	Armed Forces?  1 Never Married 2 Married 1 Yes, 200 No  1/Yes, Give Year or Dates:	1 ☐ Yes X	y Cuban, Mexica No Specify		n, etc.)	Specify: WH	e, etc. HITE
5-0036	72 hours "naturel", vical Ex	ted	15. Decedent's Education 16a, De	cedent's Usual	Occupation done during mos	st of working	16b	. Kind of Business	Industry
2		Completed	Elementary/Secondary (0-12) College (1-4or 5+)	CRETARY	retired)	st of Working		GOVERNMEN	TT
121	filed w Hygier other th		12 SE 17. Father's Name (First, Middle, Last)	CKETAKI	18. Moth	er's Name (Fin	st, Middle, Maid		N I
Maryland	ed tab	To Be	CRAWFORD HARRIS				LONG CA		
ary	o,	<b>-</b>		ailing Address (				y or Town, State, I	Zip Code)
	1 and 2 Health a tem 27 is							BURG, MD	21632
ltimore,	Pages 1 all nent of Hez int: If item iry or othe		20a. Method of Disposition  XX Burial 2 ☐ Cremation 3 ☐ Removal from State  20b. Place of Disposition State			Date		Location - City or	
Ē	그 된 본 등 .		* 4 □ Donation 5 □ Other (Specify) GLEN HA 21. Signal 1: of Funeral Service Licenses	VEN MEM	. PARK	4/27/20	005 G	LEN BURNI UNERAL HO	
Ba	permi Depa Impo eny ir		MO1415					RNIE, MD	21061
			23a. Part1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.	enter the mode	of dying, such as	s cardiac or res	spiratory arrest,		Approximate Interval Between
	Pnysician	i u	Immediate Cause (Final disease or condition and Spirate	on	mei	mor	n'a		Onset and Death
	/Medical Examiner		resulting in death)  Due to (or as a construence of)	2 0	0	emor			
		ē	Sequentially list conditions, if any, leading to immediate  b. Due to (or as a consequence of):	1 /20	Lety	2			
2	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c.						
o,	an an an irial-tr		resulting in death) Last Due to (or as a consequence of):						
8760,	icate be executed physician and s the burial-transit	dical	d						
9 xo	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23c. If yes, outcome of pregnancy					23d. Date of de	livery
Ω	death a atter d for u	iciar	23b. Was decedent pregnant in the past 12 pronths?  1 ☐ Yes 2 ☐ No	3 □Ectopic pre 5 □ Other (spe				Month	Day Year
P.0.	es that the de igned by the be detached	hys	9 Unknown						
	res tha igned be de	ρχ	Part II. Other significant conditions contributing to death but not resulting in the	e underlying ca	use given in Part	I.	23e. Did tobacc	10.7	o the cause of death?  robably 4 □Unknown
ord	w requir been si should	eted				- 4	24a. Was an	A	2
Records,	nelaw hast ge 2 s	Completed					autopsy performed	prior to death?	utopsy findings available completion of cause of
Vital	ilcien: Th certificate rector, pag	e Co	25. Was case referred to medical		26. Plac	e of Death (Cf	1 Yes 29	No 1 ☐ Yes	S X No
	Physicien: r this certifica ral director, p	To B	examiner? 1   Yes 2   Hospital: 1   Impatient 2   ER/Outpa	itient 3 DO	Other			6 □Other (Spe	ecify)
n of	ding Pt h. After th funeral		27. Manner of Death  28a. Date of Injury (Month, Day Year)  28b. Tim Inju Inju		c. Injury at Work?		Describe how in	njury occurred	
sio	Attending r death. ector: Afte by the fune	icati	2 Accident investigation 3 Suicide 6 Could not be 380 Block of Injury - At home form	M stroot factors	1 Yes 2		Location (Street	t and Number or B	ural Route Number,
Division	l or Attene after deatl Director: I in by the	Certification:	4 Homicide determined building, etc. (Specify)	, street, ractory,	Ollice	20	City or Town, S	tate)	
	To the Hospital or Attending Physicien: The within 24 hours after death.  To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	edical C	29a. Certifier (Check only one)  Medicel Examiner: On the basis of examination and/of and manner stated.						
	fo the vithin . o the omple	Mec	29b. Signature and title of certifier	29c.	License number		29d	Date signed (Mon	th, Day, Year)
	7		+ H Walksten	- D	2670	+3	3	1241	05
	3		30. Name and addiess of person who completed cause of death (Item 23a) (Ty HD Coold Stein 116 Deterse the		napol	05. M	1.21	401	
	Sta	ate	31. Date filed (Month, Day, Year)  32. Registrar's Signature	/				<u></u>	
	Regist	rar	APR 2 6 2005 Rever St.	parke	, 				
D	HMH 17 Rev 1/2	001	11 12 20 10 10 10 10 10 10 10 10 10 10 10 10 10						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [ 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** 2005 APRIL ROYSTON. CLANGO /Medical 01 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death # Davs Hours Min. May 13, 1912 Examiner Battimore Vorthweet HOS pita Birthplace (State or Foreign Country)
 Mary Land Funeral Social Security Number 7. Age (In yrs. last birthday) 1**⋈** M 2□ F Months 162-09-8549 92 Yrs. Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits 27 is markad other than "natural", or items 23a or 28a-1 show traumatic evant, the Medical Expiration must be traitified at MD Baltimore Baltimore 1 Yes 2 No Director 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 21207 U.S.A. 6825 Campfield Rd. by Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Harry T. Campbell Cement Elementary/Secondary (0-12) College (1-4or 5+) Supervisor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 2 should be fi and Mental F Anna Cameron Chester Royston 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health an Kay L. Purdum-daughter 8138 Glen Gary Rd., Baltimore, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages nent of h 1 🔀 Burial 2 ☐ Cremation 3 ☐ Removal from State = ō permit. Page Department of Important: If any injury of once. St. Abraham Lutheran 4/25/05 Hampstead, MD `4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee William G. Dau 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Rd., Towson, MD 21204 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician THEUMONIA disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** RESISTANCE STAPHYLOLOCKIES Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that intilated events resulting in death) Last THICILIN Due to (or as a consequence or Examiner certificate be executed as the burial-transit SEPSIS Due to (or as a consequence of): Box 68760, the attending physician Physician/Medical IF FEMALE: use 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) P.0. 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Ünknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an 2 N No 2 XNo 1 Yes Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No this 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification; after death. After 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) To the I within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 15 2105 APRILZO mella mo 41410 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JOGINDER P MEHTA RANDAUSTOWN MORTHWEST HOSPITAL REINTER MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

			For State Registrar	State of N	Marylan	•	artment of H				giene Reg. No.	005	14121
			Decedent's Name (First, Middle	, Last)						Date of De	ath		3. Time of Death
	Physicia /Medic		Му	riam P. Ro	llert					Month oril :	23, 2	2005 Year	11:08P M
	Examin		4a. Facility Name (If not institution	give street and numbe	r)		4b. City, Town, or	Location of	of Death		4c.	County of Dea	th
			4701 Willard A	venue, #903			Chevy C					ontgome	ry
	Funeral Director		5. Social Security Number 496-32-6810	6. Sex 1 ☐ M 2 ☑ F	Age (In yrs. 79	last birthday) Yrs.	If Under 1 Year Months Days	If Under Hours	24 Hrs. 8. [ Min. Ma	Date of Birt Month, Da rch 3	$\stackrel{\text{h}}{0},\stackrel{\text{Year}}{1}9$	26 9. Bir	thplace (State or Foreign ountry) taly
	p		Usual Residence of Decedent  10a. State 10b. County		10c Cit	y, Town or Lo	cation						10d. Inside City Limits
	shov	5			100. 01.	y, 10411 OF E0	Chevy C	haaa					1 ☐ Yes 2 🖾 No
	the M	ect	Maryland Montgo	omery			10f. Zip Code	паве			10a Citi:	zen of What Co	ountry?
	a or	ā	4701 Willard Av	zenije #903				815				ed Sta	*
	ns 23	Funeral Directo	11. Marital Status	12. Was Deceder	nt Ever in U.	S. 13. V			igin? (Specify	Yes or No		14. Race - Ame	
· _	r Itan	F	1 ☐ Never Married 2 ☑ Marri	Armed Force		ł	Was Decedent of H f Yes, specify Cuba			ın, etc.)		Black, Whi	te, etc.
ĕ	al', o	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates	s:		1 ☐ Yes 2 🔯 No	Specify:				Specify:	White
2-0	within 72 hours after death with the Maryland ene. Than "netural" or Itams 23a or 28a-f show to Medical Ezatti net must be molithed at	Completed	15. Decedent (Specify only highes	's Education		16a. Deced	dent's Usual Occup	ation during mos	t of working		16b. Kir	nd of Business	/Industry
7	ithin nan "	nple	Elementary/Secondary (0-12)	College (1-4o	r 5+)	Homer	kind of work done of DO NOT use retired	)			Or	n Home	
7	ygier ygier har th		12	( 4)		Homer	laker	10 Math	ede Name /Fi	ena Adiedello			
land	utd be fil Aental H rked ott tic evan	To Be	17. Father's Name (First, Middle, on Ottone Polley	Last)					er's Name <i>(Fil</i> ania P			Sumame)	
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.  Department of Health and Mental Hygiene.  Department of Health and Mental Health and		19a. Informant's Name/Relations Donald H. Rollen				ng Address <i>(Street a</i> V <b>illard</b> Av				-		Zip Code) Land 20815
Baltimore,	s 1 ar f Hea itam other		20a. Method of Disposition			emetery cres	sition (Name of natory or other place	(a)	Date	, [	20c. Lo	cation - City or	Town, State
Ë	Pages nent of h ant: If its ury or of		1 ☐ Burial 2 ☒ Cremation 1 ☐ Donation 5 ☐ Other (Si		®   Mor	ıtgomeı	y Lum, Inc.	I A	pril 2 2005	0,	Beth	esda, 1	Maryland
a E	permit. Departm Importa any inju		21. Signature of Funeral Service	censee		R22	Name and Address			neral	Hom	Beth	esda-Chevy se, Inc.
m	8 9 E E 8		Kont		M001	L98 75	57 Wiscon	sin Av	ve., Be	thesd	a, MI	20814	-3501
	Physician		23a. Part 1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition	only one cause on each	ed the deati line. Cance		er the mode of dyin	g, such as	cardiac or res	spiratory ar	rest,		Approximate Interval Between Onset and Death
	/Medical		resulting in death)	Due to (or a	as a conseq	uence of):						<del></del>	
	Examiner		Sequentially list conditions, if any, leading to immediate	b									
7	ed sit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or a	as a conseq	uence or):							
•	death certificate be executed e attending physician and ad for use as the burial-transit	xan	that initiated events resulting in death) Last	c. Due to (or a	as a conseq	uence of):							
760,	sician buria	calE											
89	ificati g phy as the												
×	leath certific attending p	In/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom 1 ☐ Live birth			Ectopic pregnancy				2	3d. Date of de	•
œ.	deat e att	Physician/Med	in the past 12 months? 1 ☐ Yes 2 🖾 No	4☐ Pregnant 9☐ Unknown	at time of d		Other (specify)		<del></del> -			Month	Day Year
<u>Р</u> О	that the de led by the a detached t	Phy	9 Unknown							nna Dida			a the across of death?
	og De	by	Part II. Other significant condition	ins contributing to death	n but not res	uiting in the u	nderlying cause giv	en in Part I			res 2[		o the cause of death?
Records,	w requir been si should	Completed											
Sec	e law has b	nple								24a. Was autop		prior to death?	utopsy findings available completion of cause of
										1□ Yes		1 ☐ Yes	s 2 No
Ĕ Š	Physician: Th r this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:		500	oth Oth		of Death (C/				
ō	Phys r this ral di	. To	1 ☐ Yes 2 ☒ No  27. Manner of Death	1 ☐ Inpa 28a. Date of Ir (Month, I		ER/Outpatier	IL SELDON	4 🗆 140		Describe h		Other (Spe	ecity)
on	iding Ph th. After thi funeral	tion	1 X Natural 5 ☐ Pendin 2 ☐ Accident investig		Day Year)	Injury		k? Yes 2. □	No				
Division of Vital	or Attanding after death. Director: Aftel in by the fune	Certification:	3 Suicide 6 Could r 4 Homicide determ	ined   286. Place of	Injury - At he etc. (Specif	ome, farm, str	reet, factory, office			Location (S City or Tox			ural Route Number,
	pital surs a aral Dilled i		29a, Certifier 1 🖾 Certifyin	a Physicians T- W-1	nt of musting	uulodaa daa	n occurred at the t	no dot	nd place and	duo to the	031100(-)	and manage	e stated
	To the Hospital within 24 hours a To the Funeral Completely filled	edical		g Physician: To the be Examiner: On the basis and manner	of examina					t the time,	date and	place, and du	e to the cause(s)
	To t To t	Ž	29b. Signature and title of continue				29c. Licens			1		signed (Mon	
-			///	mur			D00	23600			Apri	1 25, 2	2005
	15		30. Name and address of person Bruce R. Kresse		f death (Iten	n 23a) (Type, Lsconsi	Print) In Ave.,	#1125	, Chev	y Cha	se, l	Marylar	nd 20815
	Sta Registr		31. Date filed (Month, Day, Year)	32. Regi	rar's Signa	ture /	Sperte						

			1 - State	artment of Health and Mental rtificate of Death	2000 14126	
			Registrar  1. Decedent's Name (First, Middle, Last)		Reg. No. of Death 3. Time of Death	_
	Physici		BESSIE SLOWE	Mont ADRS	th Day Year	J
	/Medid Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death	_
			BOH SECOURS HOSPITAL	BALTIMORE	NIA	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday,	If Under 1 Year If Under 24 Hrs. 8. Date Months Days Hours Min. (Mont	of Birth 9. Birthplace (State or Foreign Country)	7
	Director		217-66-69/1 1 M 2MF 93 Yrs.	MAY		)
	land		10a. State 10b. County 10c. City, Town or L	pocation	10d. Inside City Limits	
	Mary first	tor	MARKINA N/A	BAITIMORE CIT	1√ Yes 2 □ No	
	r 288	Director	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?	
	death with the Maryland ms 23a or 28a-f show Frrust Le nutified at	aiD	2512 WEST LANVALE	21216	USA.	
	r dea	Funerai	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	Was Decedent of Hispanic Origin? (Specify Yes If Yes, specify Cuban, Mexican, Puerto Rican, etc.	tc.) 14. Race - American Indian, Black, White, etc.	
9	s afte	by Fi	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:	1 ☐ Yes 2 No Specify:	Specify:	
-0030	filed within 72 hours after death with the Marylan Hygiene Thysical Examiner roust Le nulified at ant, the Modical Examiner roust Le nulified at		· · · · · · · · · · · · · · · · · · ·	dent's Usual Occupation	16b. Kind of Business/Industry	-
<u>.</u>	72 nin 72 ni nin	Completed	(Specify only highest grade completed) (Give	kind of work done during most of working DO NOT use retired)	,	
7	d with giene. er thar	E O		TOMEMAKER	OWN HOME	
ana	be file	Be (	17. Father's Name (First, Middle, Last)	18. Mother's Name (First, M	Middle, Maiden Sumame)	
<u>X</u>	should be filed within 72 hours after death with the Mandal Hydene. Inakked other than "natural", or Items 23a or 28a-f umatic avant, Ite Madical Examinar must be nuitifu	<sup>L</sup>	WILLIAM HOLLANS		SURLEY	
Mar	12 sho h and 7 Is m traum			ng Address (Street and Number or Rural Route N	0 1 - 1 - 7	.
e) -	1 and Health am 27 ther tr		20a. Method of Disposition 20b. Place of Dispo	SCHROEDER ST. X	20c. Location - City or Town, State	-
	nit. Pages 1 and 2 should be filed within timent of heath and Mental Hygene. ordent: If Itam 27 is marked other than injury or other traumatic avant, ILa M 8.		12 Surial 2   Cremation 3   Hemoval from State   -	matory or other place)	20	10
Saltimor	permit. Pages 1 ar Department of Hea Importent: If Itam any injury or othe 2002e.		21. Signature of Funeral Service Licenspe	N PARK CEME 04-27-0 2. Name and Address of Facility	DELLERAL HAM	20
ñ	permil Depar Impor any ir		Dietich N. Williams	JUSE HULTON AV	WN JR, FUNERAL HOMO IE. BALTO, MD. 2121	7
4	7.1		23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.	ter the mode of dying, such as cardiac or respirat	tory frest, Approximate Interval Between	
	Physician		Immediate Cause (Final disease or condition Chronic Color	nectine Pulmono	Onset and Death	
	/Medical- Examiner		resulting in death)  Lue to (or as a consequence of):	<i>a</i> 1	8/.	
	Lammer	-	Sequentially list conditions, if any leading to immediate	Cardivos cular c	Disease	_
Ī	ted nsit	nine	cause. Enter Underlying Cause (Disease or injury			
	execu n and al-tra	Examiner	that initiated events c. Due to (or as a consequence of):			-
9	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	dicai	L <sub>a</sub>			
0	nifical ng phi as th	Φ	IE ECMAI C.			1
XOD D	sician: The law requires that the death certific certificate has been signed by the attending prector, page 2 should be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 moptions?  23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □	∃Ectopic pregnancy	23d. Date of delivery  Month Day Year	
5	ie dea the at hed fo	sici	1 Pes 2 No 4 Pregnant at time of death 5 9 Unknown	Other (specify)		1
Ĺ	that the		Part II. Other significant conditions contributing to death but not resulting in the u	nderlying cause given in Part I. 23e.	. Did tobacco use contribute to the cause of death?	T
corus,	signe d be	d by			1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown	ļ
2	w req beer shou	ompleted		24a.	. Was an 24b. Were autopsy findings available	-
ב ב	he la e has age 2	рто			performed? prior to completion of cause of death?	
N II G	ysician: The lavis certificate has director, page 2	e C	25. Was case referred to medical	26. Place of Death (Check of		$\dashv$
>	X S D	To B	examiner?  1 Yes 2 No  Hospital: 1 Inpatient 2 ER/Outpatien	nt 3 DOA Other: 4 Nursing Home 5	Residence 6 Other (Specify)	
	Ing P	оп:	27. Manner of Death  1 Natural 5 Pending (Month, Day Year) 28b. Time of Injury	Work?	cribe how injury occurred	
2	ttandi death. tor: /	cati	2 Accident investigation 3 Suicide 6 Could not be 390 Place of Injunt. At home farm str	M 1 Yes 2 No	tion (Street and Number or Rural Route Number,	
JIVISION	or Al after o	ertification:	determined  28e. Place of Injury - At home, farm, stibulding, etc. (Specify)		or Town, State)	
	spital lours neral filled	0	29a. Certifier 1 Certifying Physician: To the best of my knowledge, deat	h occurred at the time, date and place, and due to	to the cause(s) and manner as stated.	-
	To the Hospital or Attending Physician: which 24 hours after deals after this certificator the Funeral Director. After this completely filled in by the funeral director,	edical	(Check only one) 2 Medical Examiner: On the basis of examination and/or in and manner stated.	vestigation, in my opinion, death occurred at the t	time, date and place, and due to the cause(s)	
	To the within To the comp	Me	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)	
			Koputa K. Crus m. D	D0038355	april 22,2005	
	A		30. Name and address of person who completed cause of death (Item 23a) (Type,	Print) BON SECOL	URS HOSPITAL	
	Sta	te	COSIII N. CICA Z MILL	1 0	7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7	
	Registr		31. Date filed (Month, Day, Year)  APR 2 6 2005  32. Agistrar's Signature			

ALPHONSO

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** SCARBO ROUGH 2005 ALPHONSO 23 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Willennium Health + Rehab. Center BALTIMORE C If Under 1 Year | If Under 24 Hrs. | 114 8. Date of Birth (Month, Day, JUNE 9, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Min. 1 2 M 2 □ F 19 218-16-7111 Director Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ortant: if item 27 Is marked other than "natural", or items 23s or 28s-f show injury or other traumatic event, the Medical Examinar must be notified at 1 des 2 No Funeral Director altimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2134 USA Street 21216 Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puento Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Marned Black 1 ☐ Yes 2 ☑ No þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NDT use retired) 16b. Kind of Business/Industry Department of Health and Annual Hygiene.
Important: If Item 27 Is marked other than "na any injury or other traumatic even" income. Maryland Transit Elementary/Secondary (0-12) College (1-4or 5+) 12th Grade taministrati 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Street Marian 2134 Hshbur Baltmore MD 21216 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition
Burial 2 Cremation 20c. Location - City or Town, State 3 Removal from State NEW AUEN MEM. AME CHR. CEME 04-30-05 NORTH HAMPTON
22. Name and Address of Facility Baltmore, MD. 21217 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Joseph H. Brown, Jr. F.H. 2140 N. Fulton Avenue Vianno 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Cardio Vascular Di seaso Siles **Physician** /Medical Due to (or as a consequence of): Examiner NSION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to ( r s a consequence of) physician and the burial-tran Due to (or as a consequence of) Physician/Medical the attending pl 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) ate has been signed by the page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? Dementia 1 ☐ Yes 2 No Division of Vital or Attending Physician: funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 ☑ No Other: 4 In Nursing Home 5 Residence 6 Other (Specify) Certification: To 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After t 5 Pending investigation after death, I Director: Af 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral E

completely filled i Hospital 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai 29b. Signature and title of contifier 29d. Date signed (Month, Day, Year) 29c. License number arkaran 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SAMBANDAN BASKAKAN 3455 WILKENS BALTIMORE, MD 21219 31. Date filed (Month, Day, Year) 32. Resstrar's Signature State APR 2 6 2005

DHMH 17 Rev 1/2001

Registrar

			For Affien State Registrar	d Item	27 State 9	feMarylan	95969 Ce	denni rtificate	g of H	ealth a Death	ind M		iene ()	)5	14/24
			1. Decedent's Name (	First, Middle,	,							2. Date of Dea Month	th Day	Year	3. Time of Death
	Physici /Medic		KEITH		51	MITH						APRIL	19	2005	0344M
	Examin		4a. Facility Name (If n	ot institution, g	give street and nu	mber)		4b. City,		Location o			4c. Coun	ty of Death	^
*\$1		¥ .	JOHNS HO	PKINS	HOSDITA	L		BA		MUR		117		N/	A
	Funeral		5. Social Security Nun	nber 6	. Sex	7. Age (In yrs.		If Under Months	1 Year Days	If Under :	24 Hrs. Min.	8. Date of Birth (Month, Day	Yearl	9. Birth	place (State or Foreign ntry)
	Director		214-82-96		1 X M 2 □ F	50	Yrs.					7 16	1954		MD
	pu &	-	Usual Residence of D 10a. State	ecedent l0b. County		10c. Cit	y, Town or Lo	ocation							10d. Inside City Limits
	sho	5	MD	N,	/Δ		Baltimo								1√2Yes 2 No
	ith the Marylar or 28a-1 show se notified at	ect						10f. Zip	Codo				0g. Citizen of	What Cou	
	E or	Ö	1755 Cli		λυουμο			101. 2.10		213		'	A	itty:	
	72 hours after death with the Maryland natural', or Items 23s or 28s-1 show iteal Evantiner must be rediffed at	Funeral Director		TCATEM		edent Ever in U.	S 13	Was Deced			nin? (Spe	cify Yes or No-		ice - Ameri	can Indian
	ltem	'n	11. Marital Status  1 Never Married	1 2□ Marrie	Armed Fo	orces?		If Yes, spec	ify Cuba	n, Mexican	, Puerto I	cify Yes or No- Rican, etc.)		ack, White,	
36	rs aff	by F	X 3 ☐ Widowed 4		If Yes, Gi	ve -		1 ☐ Yes 2	No No	Specify:			Spec	ify: Bla	ck
5-0036	thou sture	ed		5. Decedent's			16a. Dece	dent's Usua	I Occupa	ation			16b. Kind of		
215	in 72	piet	(Specify Elementary/Second		grade completed) College (	1.4or 5+)	(Give	kind of wor DO NOT us	k done a e retired,	fu <i>ri</i> ng most )	of workii	ng			
212	filed within Hygiene. other than " ent, the Me	Completed	11th	iary (0°12)	N/A	1-40( 5+)	Roc	ofer					N/	'A	
	illed Hygid other ent,	Bec	17. Father's Name (Fi	irst, Middle, La	ist)					18. Mothe	r's Name	(First, Middle,	Maiden Surna	ime)	
<u>a</u>	ould be Mental arked o	To E	Thomas			Johnson Shirl						∍y	Johnso	on	
Maryland	S Pull		19a. Informant's Nam	ne/Relationshi	o (Type, Print)							l Route Number			
	1 and 2 Health a lem 27 Is		Susan Ba	tchelo	r-friend		1755	5 Clif	tvie	ew Ave	enue	Baltin	nore, M	1D 2	21213
ē,	es 1 a of He of He fitem rothe		20a. Method of Dispo			1 0	Place of Disponentery, cre-	osition (Nam	ne of ther place	θ)			20c. Location		
E	Page lent c nt: If		1 K Burial 2 ☐		B □Removal from acify)	Mt.	. Carme	el Ce	em.	- !	4/25,	/2005 F	Baltimo	ore	MD
Baltimore,	permit. Pages Department of Important: If ii any injury or o		21. Signature of Fund	eral Service Li	censee	•		2. Name an			MAR	CH F/H-I	EAST :imore,	, MD	21202
			23a. Part1. Enter the	disease, or o	omplications that of	caused the deat		1101 E						1110	Approximate
			shock, or heart Immediate Cause (Fi	failure. List or	nly one cause on	each line.			_						Interval Between Onset and Death
	Physician		disease or condition resulting in death)	illa.		ID STA		ENAL	Dis	EASE	Ī				
8	/Medical Examiner		, , , , , , , , , , , , , , , , , , , ,	- 1		(or as a conseq		41.40			~				3 VEARS
		e	Sequentially list cond if any, leading to imm	litions,		OF AS a conseq		UNC	DNT	KOLL	E1)			-	0 /2//05
	bed	ulu	cause. Enter Underly Cause (Disease or in	/ing		(0. 40 4 00.004								II.	3 YEARS
	executed n and ial-transit	Examin	that initiated events resulting in death) La		c	(or as a conseq	uence of):								5 /55
8760	be e iiclan buria	a													
87	phys the	edicai			d										
9 X	death certificate be executed e attending physiclan and of for use as the burial-transit	/Me	IF FEMALE:		23c. If yes, ou	tcome of pregna	ancy						23d. D	ate of deliv	rerv
Вох	atten for u	Physician/M	23b. Was decedent p in the past 12 m	onths?	1 Live I	birth 2 Feta nant at time of d	I death 3[	⊒Ectopic pr						lonth	Day Year
P.O.	he d	ysic	1 □ Yes 2 □ I 9 □ Unknown	No	9☐Unkn			_ O (s/a	,/						
	equires that the de een signed by the a rould be detached t	/Ph	Part II. Other signific	ant condition	s contributing to d	leath but not res	ulting in the u	inderlying ca	ause give	en in Part I.		23e. Did to	bacco use co	ntribute to I	the cause of death?
ds,	sign d be	d b	AIDS									1 🗆 Y	es 2 No	3 🗆 Pro	bably 4 Unknown
Division of Vital Records,	_ ~ _	Completed by										24a. Was a	ın 24h	Were aut	opsy findings available
3ec	e law has	шb										autops	sy	prior to co death?	ompletion of cause of
al	: The licate ha												2 XNo	1 🗌 Yes	2 No
VIE	Phyaician: The law this certificate has be ral director, page 2 s	Be	25. Was case referre examiner?		Hospital:		·		Othe			(Check only or			
of	this ald	. To	1 Yes 2 N 27. Manner of Death	0	1 1 1		ER/Outpatie		/A	4 🗆 140		ne 5 Reside			<i>Ty)</i>
UC	ding F	tion	1 XNatural	5 Pending		of Injury nth, Day Year)	Injury	м	8c. Injury Work	(? Yes 2 □:			,.,.,		
Sic	tten deatl stor: / the	Certification:	2 Accident 3 Suicide	6 Could no	ot be	e of Injury - At he	ome, farm, st					28f. Location (S	treet and Nun	nber or Rur	al Route Number,
Ì	or A after Direct in by	ertii	4 🗌 Homicide	determin	build	ling, etc. (Specif	<i>(y)</i>	. actory	, 011100			City or Town	n, State)		
	pital ours a eral filled	Ö	29a. Certifier 1	` <b>⊠</b> Certifying	Physician: To the	a best of my kno	wledge, deal	h occurred	at the tim	ne date an	d place, a	and due to the c	ause(s) and n	nanner as s	stated.
	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the fune	edical			xaminer: On the b										
	o the ithin of the smple	Mec	29b. Signature and to	tle of certifier				290	. License	number		2		ed (Month,	Day, Year)
	F ≥ F 8		) yms		. DO.			14	1000	5524	15		4/20	1/65	_
			30. Name and addres			so of doath (list	n 29a\ /*···								
	2		W. / I	IJ D	no completed cau	A A A	LVa T	ردانال) حد	R	11-9-1022	100.00	ma al	207		
	Sta	to	William 31. Date filed (Month	Day, Year)	32.1	egistrar's Signa	ature	C 31.	PA	un / ////	JENC T	114 81	×37		
	Regist		A	PR 2 6	2005	MELAN I	li A	made							
		7			1	-	-								

		-	For State Registrar	State of Marylan	d / Depa		Health and N	Mental Hyg	_	15	Entering of the second	25
	Physicia /Medic		Decedent's Name (First, Middle, Last)     Moses	Edward		Samue:	l, Jr.	2. Date of Deat Month APRTL	20, 20		3. Time of 0 9:19a	Death M
}	Examin	0.5	4a. Facility Name (If not institution, give st BAY SOX STADIUM, 410	reet and number) 1 CRAIN HIGH	WAY	BOWIE	or Location of Death		PRINCE	of Death GEOR	RGES	
	Funeral Director		5. Social Security Number  231-74-5216  Usual Residence of Decedent	7. Age (In yrs. I	last birthday) Yrs.	If Under 1 Yea Months Days		8. Date of Birth (Month, Day, 9-30-5	Year)	9. Birthpla Count	ace (State or ry) Va.	11
	Maryland I-f show	tor	10a. State 10b. County Va. Caroline		y, Town or Lo Ruther				· · · · · · · · · · · · · · · · · · ·	10	d. Inside City	
	3s or 28e	i Director	10e. Street and Number 13181 Samuels Lan	e		10f. Zip Code	546	1	0g. Citizen of V U	What Count	ry?	
920	be filed within 72 hours after death with the Maryland ital Hygiene. id other then "naturel", or items 23a or 28a-f show event, the Medical Estalinal must be notified at	by Funerai		2. Was Decedent Ever in U. Armed Forces? 1 ∐Yes 2 XNo If Yes, Give Year or Dates:		Was Decedent of If Yes, specify Cu 1 ☐ Yes 2 🖾 N	Hispanic Origin? (Sp ban, Mexican, Puerto o <i>Specify:</i>	pecify Yes or No- Pican, etc.)		e - America ck, White, e Bla		
Maryland 21215-0036	filed within 72 ho Hygiene. thar than "natur. int, II.a Medical.	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) 10th grade		(Give	dent's Usual Occ kind of work don DO NOT use retii uck Driv	e during most of worl red)	king	16b. Kind of Bu		<sup>ustry</sup> Compan	ıy
land;	ed ita	To Be C	17. Father's Name (First, Middle, Last)  Moses E	. Sar	muel,S	c.	18. Mother's Nam Helen	e (First, Middle, I		woolf	olk	
	os 1 and 2 of Health ar of Health ar if itam 27 is r othar trau		19a. Informant's Name/Relationship (Type Helen V. Woolfolk  20a. Method of Disposition  1 Burial 2 Cremation 3 Re	Samuel Mother	er 1. Place of Dispo	3181 Sam esition (Name of matory or other p		, Ruther	Glen, 20c. Location -	Va. City or Tov	22546	
Baltimore,	permit. Pag Department Important: I any injury o once.		21. Signature of Funeral Service License		22	aptist C <sup>2. Name and Add</sup> March F.	ress of Facility	Balti	more, M North	d. 2	1202	
760, <	/Medical Examiner /Medical Examiner	cal Examiner	23a. Part1. Enter the disease, or complic shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, resulting to manuscript cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseq	uanca ot:		AS N.C. GAMO		ENORIA		Approximate Interval Betwo	ween
P.O. Box 68	ne death certific the attending pi hed for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	ic. If yes, outcome of pregna 1 Live birth 2 Feta 4 Pregnant at time of d	ıl death 3[	□Ectopic pregnar □ Other (specify)				te of deliver	-	'ear
	v requires that it been signed by should be detac	by	Part II. Dther significant conditions con	tributing to death but not res					oacco use cont es 2 □ No		e cause of deably 4 💢 🕻	
Records,		Completed	CARDIO VAS W	AN DISEX	ASE.			24a. Was a autops perform	med?	prior to com death?	osy findings a apletion of ca 2 No	vailable suse of
Vital	Physician: Th this certificate ral director, pag	To Be	25. Was case referred to medical examiner? 1 X Yes 2 □ No	ospital:	l ER/Outpatie	nt 3CIDOA	26. Place of Dea Other: 4 Nursing H	th (Check only or		er (Specify	SCENE	ã.
on of	ling Pt. After th		27. Manner of Death  1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o	of 28c. In W	jury at /ork?	28d. Describe h	ow injury occur	red	SCHILE	
Division	l or Attanding after death. Diractor: After s in by the funer	Certification;	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Specif	ome, farm, st fy)			28f. Location (Si City or Town		er or Rural	Route Numb	ber,
	To the Hospital or Attanding Ph within 24 hours after death. To tha Funaral Diractor: After th completely filled in by the funeral	Medical C	29a. Certifier 1 Certifying Phys (Check only one) 2X Medical Examin	ician: To the best of my kno er: On the basis of examina and manner stated.	owledge, dear ation and/or in	th occurred at the extigation, in m	time, date and place y opinion, death occu	, and due to the c rred at the time, d	ause(s) and ma ate and place,	anner as sta and due to	ated. the cause(s)	}
	To the within 2 To tha complete	W	29b. Signature and title of certifier	1		29c. Lice	nse number		9d. Date signe	d (Month, E		
	2		30. Name and address of person who con	1 4 -	m 23a) (Type		Penn Stre	et Balt	imore	Marv1	land 2	1201
	St Regist		31. Date filed (Month, Day, Year)	32, Registrar's Signa	ature A				- market g	THAL Y	curu Z	±4VI
			APR 2 6 200	S FERREN PO	17							

			1 - For State Registrar		State of Ma	aryland		artment of F		Mental Hy	giene Reg. No.	.000	14126
			Decedent's Name (First, II	1iddle, Las	et)				<u> </u>	2. Date of De	eath		3. Time of Death
	Physici /Medic		ALVA					SMITH		Month	17 Day	y Year	
}	Examin		4a. Facility Name (If not insti	tution, give	street and number)	. (		4b. City, Town, o	Location of Dea	th	4c.	County of Dea	ath
			The Johns		okins Hi	25101	14	391	If Under 24 Hrs	city		NA	
	Funeral Director		5. Social Security Number 220–74–5489	6. Se	□M 21277.F	e (In yrs. la	st birthday) Yrs.	Months Days	Hours Min	(Month, D	ay, Year)	9. Bii	rthplace (State or Foreign country)
			Usual Residence of Deceder	nt		88				6-1	0–16		N.C.
	show		10a. State 10b. Co	unty		10c. City,	Town or Lo						10d. Inside City Limits
	8e-1 s	cto	Md.		NA		Ba.	ltimore					1 ∑ Yes 2 □ No
	with the	Dire	10e. Street and Number	สสา	Chanash			10f. Zip Code	120		10g. Cit	tizen of What C	
	eath	erai	3108 E. Bi	aare	12. Was Decedent	Ever in U.S	13	212		Specify Yes or N	n-	USA 14. Race - Am	
21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. Health and Mental Hygiene. Item 27 is marked other then "neturel; or iteme 23a or 28e-f show other treumatic event, the Muchael Examinate results be notified at	by Funeral Director	1 □ Never Married 2 □  3 ☑ Widowed 4 □ Divo		Armed Forces? 1 ☐ Yes 2 1 If Yes, Give Year or Dates:		- 1	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 X No	in, Mexican, Puel Specify:	rto Rican, etc.)		Black, Whi	
5-0	72 ho	Completed	15. Dec (Specify only t	edent's Ed			16a. Dece	dent's Usual Occup	ation during most of we	orkina	16b. K	and of Business	s/Industry
121	within ene then "	mpie	Elementary/Secondary (0-		College (1-4or 5	i+)	life.	DO NOT use retired	1)			_	
	filed withi Hygiene. other then ent, Ire M		17. Father's Name (First, Mi	ddie Last)			<u>L</u> i	aborer	18 Mother's Na	ıme (First, Middle		aundry	
Maryland	should be tind Mental I	o Be	Elijah	, Lust,	Н	inton			Mary			•	Miles
ary	2 shoul and Me is marl	Ĕ	19a. Informant's Name/Rela	tionship (7			19b. Maili	ng Address (Street			er, City o	or Town, State,	Zip Code)
	1 and 2 Health a tem 27 is		Linda Lomax		Daughter		3108	E. Bidd]	e Street	t, Balti	more	, Md.	21213
ore	ges 1 ar t of Hea if item or other	1	20a. Method of Disposition 1 ☑ Burial 2 ☐ Crema	tion 3 🗆	Removal from State	20b. Pla	netery, crei	osition (Name of matory or other plac	ce)	Date	20c. Lo	ocation - City o	r Town, State
Ë	Pag ment ent: i		`4 □Donation 5 □Oth			Mt.	Calv	ary Cem.	4-:	26–05	An	ne Arun	del Co, Md.
Baltimore,	permit. Pages. Department of the Importent: If ite any injury or of once.		21. Signature of Funeral Se	adı	x W	ane	ا حر	Name and Addre	. East	1101	E. W	ore, Md orth Av	. 21202 e.
			23a. Part1. Enter the diseas shock, or heart failure.	e, or comp List only	ations that caused one cause on each li	the death. ne.	Do not ent	ter the mode of dyin	g, such as cardia	ac or respiratory a	arrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)		a Hyper	aluc	emi	Con	200				Onset and Death Ten Day S
	/Medical Examiner		resulting in death)		Due to (or as	a cons lue	ence of):						-
		ē.	Sequentially list conditions, if any, leading to immediate		b. Pheor								Three Weeks
V	uted d ansit	min	if any, leading to immediate Cause (Disease or injury that initiated events	1									
oʻ	icate be executed physician end s the burial-transit	Examiner	resulting in death) Last		Due to (or as	a conseque	ence of):						
68760,	ite be iysicia ne bui	edicai			d								
			IF FEMALE:								-		
Вох	death certificate be executed e attending physician end nd for use as the burial-transit	Physician/M	23b. Was decedent pregnar in the past 12 months?	11	23c. If yes, outcome 1 Live birth	2 Fetal	death 3	Ectopic pregnancy	,			23d. Date of de Month	Day Year
	\$ 0 D	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown		4□Pregnant at 9□Unknown	time of dea	ath 5L	Other (specify)					
P.0	The law requires that the de Nte has been signed by the a bage 2 should be detached 1	/Ph	Part II. Other significant co	nditions o	ontributing to death b	ut not resul	ting in the u	nderlying cause giv	en in Part I.	23e. Did	tobacco i	use contribute	to the cause of death?
sp.	uires 1 sign 11d be	d by			-					1 🗆	Yes 2	□No 3□F	robably 4 Honknown
00	aw requir as been si 2 should	Completed								24a. Wa		24b. Were a	utopsy findings available
Re	The lav	mo								auto perf 1  Yes	ormed?	death?	
of Vital Records,		BeC	25. Was case referred to me examiner?	dical					26. Place of De	ath (Check only			
) \	Physicien: this certific ral director,	ို	1 ☐ Yes 2 ☐ 110		Hospital: 1 Impatie		R/Outpatier		4 🗆 Nursing	Home 5 Res	idence	6 □Other (Sp	ecify)
		ion:		ending	28a. Date of Inju (Month, Da	ry y Year)	28b. Time o Injury	Wor		28d. Describe	how inju	ry occurred	
isio	Attending r death. ector: After by the fune	icat	3 ☐ Suicide 6 ☐ C	vestigation ould not be		ury - At hon	ne farm st	M 1 [	Yes 2□No	28f Location	(Street ar	ad Number or F	Rural Route Number,
Division	lor A after Direction by	Certification;	4 Homicide	etermined	building, et	c. (Specify)	ie, iaitii, st	eet, factory, office		City or To			iorar riodia recitoar,
_	To the Hospitel or Attent within 24 hours after deall To the Funeral Director: completely filled in by the	Medical C	29a. Certifier 1 Certifier (Check only one)	tifying Ph lical Exan	ysician: To the best niner: On the basis o and manner st	f examination	ledge, deat on and/or in	h occurred at the tir vestigation, in my c	пе, date and place pinion, death occ	e, and due to the curred at the time	cause(s)	) and manner a d place, and du	s stated. e to the cause(s)
	To the Within To the	Me	29b. Signature and title of co	ertifier				29c. Licens	e number		29d. Da	te signed (Mon	eth, Day, Year)
			Adleh	Sur	eco, mi	>		RES	-000		APR	14 17	, 2005
	11		30. Name and address of pe	_									STREET
	7		ADLAH SUKKA		OWER 110			opkins il	SPITAL	BALTIM	cre,	MARYL	AND 21287
	Sta Registi		31. Date filed (Month, Day, APR 2		32. Registr			ه م					
			ni i	) <u>400</u> ;	Marie		1004						

Lan	a Sims		1 - State Unpend Item Registrar	State of 1 23a,27,28	Maryland/Depa Ba-f per me	rtment of Heather of Deather	alth and Me tas eath	ental Hygie Reg.	ne 0 0 5	14127
	Physici	an.	1. Decedent's Name (First, Middle, I	- •				2. Date of Death Month	Day Year	3. Time of Death
	/Medic		Allana	Sims				pril 21	2005	07:16 A <sup>M</sup>
1	Examin	er	4a. Facility Name (If not institution, g		θr)	4b. City, Town, or Lo			4c. County of Dea	
	, Funeral		St. Agnes Hospit 5. Social Security Number 6.		Age (In yrs. last birthday)			R Date of Birth	Baltimore	City thplace (State or Foreign
3	Director		N/A	1□M 2 <b>汉</b> F	Yrs.	Months Days F	Hours Min.	(Month, Day, Ye	9 <i>ar</i> )	MD
	pu k		Usuaf Residence of Decedent  10a. State 10b. County		10c. City, Town or Lo	ostion				
	Aanyian f show	ŏ	MD N/	A	Baltimo					10d. Inside City Limits 1 Yes 2 No
	28a-	rect	10e. Street and Number			10f. Zip Code		10g.	Citizen of What Co	
	death with the Maryland ms 23a or 28a-f show Irrust to notified at	a D	3713 Edmondson	Avenue		21229			USA	
	items (	Funeral Director	11. Marital Status	12. Was Decede		Was Decedent of Hispa f Yes, specify Cuban, N	anic Origin? (Spec Mexican, Puerto R	ify Yes or No-	14. Race - Ame Black, Whit	
36	s 1 end 2 should be filed within 72 hours after death with the Maryla I Health and Mental hygiene. Item 27 is marked other than "natural", or Items 23a or 28a-1 show ther traumatic event. Ite Medical Examinat must be indiffied at	by Fu	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 29 If Yes, Give Year or Date	<b>K</b> No		Specify:			Black
21215-0036	2 hou	ted	15. Decedent's	Education	16a. Deced	lent's Usual Occupation	n	166	o. Kind of Business	
215	within 7. ene. than "n	Completed	(Specify only highest of Elementary/Secondary (0-12)	college (1-4	life I	kind of work done durii DO NOT use retired)	ng most of working	9		
	filed wi Hygien ther th		N/A	N/A	N	/A			N/A	
Maryland	should be filed within and Mental Hygiene. marked other than imatic event.	Be	17. Father's Name (First, Middle, La Steve Sim	•		18		(First, Middle, Maid	·	
Ž	thould id Mei mark matic	ဥ	Steve Sim  19a. Informant's Name/Relationship		19h Mailir	ng Address (Street and	Quanti:		Fleet	Zin Code)
	nd 2 s alth ar 27 is r trau		Leslie Rice-aunt	(1),20,11,110,		Round Road				21225
Je,	item othe		20a. Method of Disposition		20b. Place of Dispo	THE RESERVE TO SERVE THE PARTY OF THE PARTY	Da		. Location - City or	
Ĭ,	Page nent c ant: If ary or		1 ⊈Burial 2 ☐ Cremation 3 1 ☐ Cremation 3 ☐ Other (Special Control of Contr		110	Cemetery	4/25/2	2005 Ba	altimore	MD
Saltimore,	permit. Pages 1 end 2 sh Department of Health and important: If Item 27 is in any injury or other traum 90008.		21. Signature of Funeral Service Lic	ensee		. Name and Address o				AST
	707 e 0		23a. Part1. Enter the disease, or co	¿ Wo		101 E. Nort				21202 Approximate
	Medical Examiner buysicien and	al Examiner	fmmediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or	Unexplained as a consequence of): as a consequence of):	Death in I	nfancy(S	UDI)		Interval Between Onset and Death
P.O. Box 68760,	t the death certif by the attending ached for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		n 2 ☐ Fetaf death 3 ☐ It at time of death 5 ☐	DEctopic pregnancy			23d. Date of de Month	ivery Day Year
	98	by	Part II. Other significant conditions	contributing to deat	h but not resulting in the u	nderlying cause given i	n Part I.	23e. Did tobac		o the cause of death?
ecords,	> 5 %	letec						24a. Was an		
$\alpha$	has has	Completed						autopsy	prior to death?	utopsy findings available completion of cause of
ita	ysician: Th is certificate director, pag	Be C	25. Was case referred to medical examiner?			26	6. Place of Death	1X Yes 2 (Check only one)	No 18 Yes	2 □ No
of Vital	Physician: this certific rai director,	P	Yes 2□No	Hospital: 1 🗌 Inp				e 5 🗆 Residence	e 6 Other (Spe	
o uc	fter fre	Certification:	27. Manner of Death 1 ☐Natural 5 ☐ Pending	Fould to	Day Year) Found:	Work?	2 <b>X</b> No	3d. Describe how i	injury occurred	unk
Division	Attending r death.	ficat	2 Accident investigat 3 Suicide Could not determine	4-21-0	Injury - At home, farm, str			of, Location (Stree	t and Number or Ri	ural Boute Number
Div	al or A	ert	4  Homicide determine	building	Residence	eet, idetely, emse	Ba	City or Town, S	City, Man	ural Route Number. Imondson Ave. ryland
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical C	29a. Certifier 1 Certifying (Check only one) 2 Medical Ex	Physician: To the be	est of my knowledge, death s of examination and/or in-	n occurred at the time, overstigation, in my opinion	date and place, an	nd due to the cause	e(s) and manner as	stated
	o the	Me	29b. Signature and the of certifier	and manner	74.4	29c. License nu	umber	29d.	Date signed (Mont	h, Day, Year)
	F ≯ F Õ		AL SIL	tur		OCME			cil 22 20	
			30. Name and address of person wh	o completed cause	of death (Item 23a) (Type,					
			31. Date filed (Month, Day, Year)	JE14K	jettarie Sinnature	111 Pe	enn Stree	t Balti	more, Mar	ryland 21201
	Sta Registi		31. Date filed (Month, Day, Year) APR 2 6	2005	istrar's Signature	Section				

DHMH 17 Rev 1/2001

Registrar

2005

SWEEDER

2005

			1 - For State Registrar	State of Ma	ryland /		artment c rtificate			and M		jiene	005	)	Annual of the second	29
			1. Decedent's Name (First, Middle, La	st)	-						2. Date of Dea Month	th Day		021	3. Time of	Death
	Physici /Medio		Frederick Wa	rren Smith	nerman						April	23,	20	ear 05	4:00	ΑM
	Examin		4a. Facility Name (If not institution, give	e street and number)			4b. City, Tov	wn, or l	ocation o	f Death		4c.	County of	Death		
			Laurel Regional					aur							eorge's	
	Funeral Director		214-28-4605	ex 7. Age ZMM 2□F	(In yrs. last	birthday) Yrs.	If Under 1 Y Months Da	ear ays	Hours	Min.	8. Date of Birth (Month, Day May 23,	Year) 193		Cou	place (State of ntry) yland	r Foreign
	pur *		Usual Residence of Decedent  10a, State 10b, County		10c. City, T	own or Lo	cation								I Od. Inside Cit	ty Limite
	death with the Maryland ms 23s or 28s-f show finast be notified at	ក	,	Coommola											1 🗌 Yes	
	28a-1	Director	MD Prince  10e. Street and Number	George's	Lau:	rer	10f. Zip Co	de				Ing Citi	zen of Wh	at Cou	ntn/2	
	with Be or		6002 Maple Ter	race				707	,			<b>.</b>	USA	at 000	,	
	death ms 23	era	11. Marital Status	12. Was Decedent B	ever in U.S.	13.				gin? (Spe	ecify Yes or No-		14. Race -		can Indian,	
36	be filed within 72 hours after death with the Marylan tal Hygiene. Id other than "natural", or items 23s or 28s-1 show avent, the Modical Examinational be netitined at	by Funeral	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	Armed Forces?  XXYes 2 □ N  If Yes, Give  Year or Dates:	1951 -1954	_	fYes, specify 1 □ Yes 2 🔀		, Mexican Specify:	, Puerto	ecify Yes or No- Rican, etc.)		Black, Specify:		etc. ite	
Maryland 21215-0036	2 hou	ed	15. Decedent's Ed	ducation	1	6a. Dece	dent's Usual O	ccupat	tion			16b. Ki	nd of Busin	ness/Ir	dustry	
212	filed within 72 Hygiene. other then "nei set, the Mudic	Completed	(Specify only highest gra Elementary/Secondary (0-12)	de completed) College (1-4or 5	+)	(Give	kind of work d DO NOT use r	fone du etired)	iring most	t of worki	ng	Lav	rel 1	Pap	er & Me	etals
7	2 should be filed within n and Mental Hygiene. is marked other than 'reumatic event, Ite M.	mo.	7th	Ø	.,	Owne	er-Oper	ato	r			Rec	cycli	ng i	Company	Y
g	al Hy d oth	Be	17. Father's Name (First, Middle, Last,						18. Mothe	r's Name	(First, Middle,	Maiden	Sumame)			
<u> </u>	uld b Ments arked	70 E	George Robert Sm	nitherman,	Jr.				Agn	es-L	ouise B	arto	n			
a	2 sho and I is me		19a. Informant's Name/Relationship (	Type, Print)	1	19b. Mailir	ng Address (St	treet ar	nd Numbe	r or Rura	I Route Numbe	r, City o	r Town, St	ate, Zij	Code)	
	and 2 balth n 27 her tr		Betty Neal/Daught	er			THE REAL PROPERTY.		rrac		aurel,	MD	2070	7		
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta important: if item 27 is marked any injury or other traumatic espece.		20a. Method of Disposition  1X Burial 2 ☐ Cremation 3 ☐  4 ☐ Donation 5 ☐ Other (Specif.		ceme	etery, crei	sition (Name of matory or other Cemete	r place,	· i		/2005		cation - Ci irel,		own, State	
Balti	permit. Departri Imports any inju		21. Signature of Funeral Service Licer	1	00160	22					aldson e, Laur			Home	•	
			23a. Part1. Enter the disease, or com	plications that caused	the death. [	Do not ent							_		Approximate	3
3	Pnysician		shock, or heart failure. List only Immediate Cause (Final		θ.										Onset and D	Death
	/Medical		disease or condition resulting in death)	a Stroke Due to (or as a	a consequen	ce of):								+	3 days	3
	Examiner			Atheros			ardiov	asc	ular	Die	A25A				20 <b>5</b> ye	arc
		ē	Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury	b. Due to (or as a			Jararov	abc	ulul	טבט	casc			-	-0 3 90	Jara
1	uted d ansit	Examiner	Cause (Disease or injury that initiated events	Hyperte	ension										20 + ye	ears
o o	exec an an rial-tr	Exa	resulting in death) Last	Due to (or as a	consequen	ce of):										
58760,	icate be executed physician and s the burial-transit	dical		d. Diabete	es Mel	litus	5								5 ye	ears
Box	eath certific attending p I for use as	an/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of			∃Ectopic pregn	ancv				2	23d. Date of		-	
o.	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at 9☐ Unknown			Other (specif						Month		Day Y	/ear
סי	s that ned b	by P	Part II, Other significant conditions of	contributing to death bu	ut not resultin	ng in the u	nderlying caus	se giver	n in Part I.		23e. Did to	bacco u	se contribi	ute to t	he cause of d	eath?
Records,	quire n sig uld b	pe pe									1 □ Y	es 2[	□No 3Ž	Pro	oably 4 □U	Inknown
000	s been si s should I	Completed									24a. Was a		24b. We	re auto	psy findings a mpletion of ca	available
	sician: The law certificate has b irector, page 2 s	Ë									autop	med?	dea	ith?		ause of
Vita	an: T	BeC	25. Was case referred to medical						26 Place	of Death	1 Tes	2 X No		Yes	2[XNo	
	ysician: is certific director,	To B	examiner? 1 □ Yes 2 🎛 No	Hospital:	nt 2□EB	/Outpatier	nt 3 DOA				me 5 Resid		S □Other	(Sneci	5v)	
Division of	ding Ph n. After th funeral		27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injur (Month, Day		b. Time o Injury		Injury Work	at		28d. Describe h				,,	
Visi	I or Attendi after death. Director: A I in by the fu	Certification;	2 Accident investigation 3 Suicide 6 Could not b 4 Homicide determined	e Geo Blood of Inju	ry - At home	, farm, sti				100	28f. Location (S City or Tow	treet an n, State	d Number	or Run	al Route Numi	ber,
	ital c		V	1						-					·	
	To the Hospital or within 24 hours affe To the Funeral Dir completely filled in	Medical	29a. Certifier 1♣ Certifying Pt (Check only 2 Medical Examone)	nysician: To the best of miner: On the basis of and manner sta	examination	dge, deat and/or in	h occurred at ti vestigation, in	my opi	e, date an inion, deal	d place, th occurr	and due to the d ed at the time, d	ause(s) late and	and mann place, and	er as s d due t	tated. o the cause(s)	)
	To t To t	Σ	29b. Signature and title of certifier	amelli	7	11	29c. Li		number	-					Day, Year)	
	217		Temoth 1	1111 ClA	m /	VI	7	D	395	5 3	2	AP	ul	23	,200	15
	154		30. Name and address of on who Timothy McClair				Print) orge St	ree	t, L	aure	1, MD	2070	17			
1	Sta Registi		31. Date filed (Month, Day, Year)  APR 2 6	32. Registra	r'e Cianatur											

			For State Registrar	State of Ma	ryland / Dep		lealth and M	lental Hygi	-	5 14130
	Dhoolet		1. Decedent's Name (First, Middle, La	ist)				2. Date of Death Month		3. Time of Death
	Physici /Medio Examir	al	Stephe 4a. Facility Name (If not institution, given	en S. Small	ow, Sr.	4b. City, Town, o	or Location of Death		22, 200 4c. County of	
			936 Burnett Ave	nue			mold			Arundel
Ī	Funeral Director		5. Social Security Number 6. 9	Sex 7. Age	(In yrs. last birthday 80 Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, AUG 19,	1924 <sup>9</sup>	Birthplace (State or Foreign Country) Pennsylvania
	and and	1	Usual Residence of Decedent  10a. State  10b. County		10c. City, Town or L	ocation				10d. Inside City Limits
	the Mary 28a-f sh	ector	Maryland Anne A	rundel		Arno]	Lđ	10	- Civi (MI)	1 ☐ Yes 2X No
	th with 23a or	al Dir	936 Burnett Ave	nue			21012	10	g. Citizen of Wha US.	A
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic evant, I'm Medical Examinar must be invitibled at once.	by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 Types 2 N If Yes, Give Year or Dates:	ver in U.S. 13.	Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 ☐XNo	Hispanic Origin? (Spe an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		American Indian, White, etc. White
21215-0036	- 1 10	Completed by	15. Decedent's Eigenentary/Secondary (0-12)	ducation ade completed) College (1-4or 5-	(Giv	edent's Usual Occup e kind of work done DO NOT use retire	oation during most of worki d)	ing 1		Contract
	iled w lygier ther th		17. Father's Name (First, Middle, Lasi	4	Elec	etrical E	ngineer 18. Mother's Name	/Fires Adjustin Ad		Government
land	id be f ental l ked of ic eva	To Be	Stephen Small				Anna I		alden Sumame)	
Maryland	permit. Pages 1 and 2 should be filed withir Department of Health and Mental Hygiene. Important: If item 27 Is marked other than any injury or other traumatic evant, Item Mangore.	<b>—</b>	19a. Informant's Name/Relationship	Type, Print)		ing Address (Street Burnett	and Number or Rura			
	Healt Healt tam 2		Stephen Smallow, 20a. Method of Disposition	JL . / SUII		osition (Name of omatory or other place			Oc. Location - Cit	
OM	Pages nent of int: If it iry or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ 1 ☐ Donation 5 ☐ Other (Special Control of Co	Removal from State			Inc. $4/22$		Baltimo	
Baltimore,	permit, Departm Importa any inju		21. Signature of Funeral Service tice	Mr. Dmuld	) (	2. Name and Addre	Society o	of Maryla	and, Inc	· Indiana and
	2.0		23a. Part1. Enter the disease, or con shock, or heart failure. List only	nald  plications that caused  one cause on each line						Approximate Interval Between
	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	a. WA	consequence of):		27 92			Onset and Death
	be executed ician and burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	consequence of):					
68760,	cate be ex physician a	cal	Totaling in totaling East	d	consequence of):			<u>-</u>		
O. Box	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the buriat-transit	Completed by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	23c. If yes, outcome of 1 Live birth 2 4 Pregnant at 1 9 Unknown	2 Fetal death 3	⊒Ectopic pregnancy ⊒ Other (specify) _	<i>y</i>		23d. Date o Month	
rds, P	quires that an signed t uid be det	ed by P	Part II. Other significant conditions	contributing to death bu	t not resulting in the	underlying cause giv	ven in Part I.			ite to the cause of death?
I Records,	The larate has	Somplet						24a. Was an autopsy perform	prio dea	re autopsy findings available r to completion of cause of th? Yes 2
Vital	Physician: this certific ral director,	Be	25. Was case referred to medical examiner?	11. 2.1			26. Place of Death			
of	Physic r this c	. To	1 Tes 2 No	Hospital: 1 Inpatier			4   Nursing Hor	ne 5 Nesiden 28d. Describe how		(Specify)
ion	Attanding r death. actor: After by the funer	atlor	1 Pending 2 Accident S Pending	(Month, Day	Year) Injury	Wor	k? Yes 2□No	200, 2000, 100	injury occurred	
Division	I or Attandi after death. I Diractor: A d in by the fu	Certification:	3 Suicide 6 Could not be determined		ry - At home, farm, s . (Specify)	treet, factory, office		28f. Location (Stre City or Town,	et and Number ( State)	or Rural Route Number,
	To the Hospital or Attanowithin 24 hours after death To the Funaral Diractor:	edical C	29a. Certifier (Check only one)  1 Dertifying P	nysician: To the best o miner: On the basis of and manner stat	examination and/or i	th occurred at the tir nvestigation, in my o	me, date and place, a ppinion, death occurr	and due to the cau ed at the time, dat	se(s) and manne e and place, and	er as stated. I due to the cause(s)
	To th withir To th comp	Me	29b. Signature/and title of centier		\	29c. Licens	se number	290	d. Date signed (A	Month, Day, Year)
•	· 1 N		* ACKENTING	of my	)	7)(	6569	+	TPRIL:	22, 2005
0	XX.		30. Name and address of person who	E MM 90	DRAIG	FIT RD	300 Y	MARQUE	Cu 2	2(40)
	Sta Registr	45.5	31. Date filed (Month, Day, Year)		s Signature	from	P			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 0 5 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year Joseph Earl Somers 25 APR 11: OLAM 2005 4a. Facility Name (If not institution, give street and number)

900 CATON AVE ST. AGNES 4c. County of Death 4b. City. Town, or Location of Death HEAGTH BALTIMOR n/a Under 1 Year If Under 24 Hrs. 8. Date of Birth Country Days Hours Min. March 31, 1928 Maryland 5. Social Security Number 6. Sex 1X M 2 ☐ F 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) Months 216-24-0308 Usual Residence of Decedent 10c. City, Town or Location 10a State 10b County 10d. Inside City Limits 1 X Yes 2 ☐ No Maryland n/a Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3913 Colchester Road 21229 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ZYes 2 ☐ No 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married If Yes, Give Year or Dates 1946–47 1 ☐ Yes 2 XNo Specify: Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) umpire sports 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Frank Somers Eva Flack 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Somers - wife 3913 Colchester Road, Baltimore, Maryland 21229 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State 1 ∑Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Crestlawn Gardens 4/29/2005 Marriotsville, MD 21. Signature of Funeral Service License 22. Name and Address of Facility Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List gnly doe cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CHRONIC OBSTRUCTIVE PULMONARY DISEASE UNKNOWN disease or condition resulting in death) Due to (or as a consequence of): HEART FAILURE JNKNOW ONGESTIVE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome of pregnancy
1□Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ULCERATIVE CONTIS 1 Yes 2 No 3 Probably & Unknown RHFUM ATO 10 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1□ Yes 2 □ M6 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1□Yes 2☑No Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No

Examiner The law requires that the death certificate be executed attending physician and this certificate has Division of Vital or Attending Physician: atter death.

Examiner Physician/Medicai þ Completed Be Certification: To in by the tuneral Medical

**Physician** 

/Medical

Examiner

**Funeral** 

Director

or 28a-f show

Iteme 23a

ö

"naturel",

permit. Pages 1 and 2 should be tiled within 7 Department of Health and Mental Hygiene. Importent: If tiem 27 is marked other then "na any injury or other treumatic avant

**Physician** 

/Medical

Director

Completed by Funeral

treumatic event, the Medical Examiner must be notified at

the Maryland

liled within 72 hours after death

3altimore, Maryland 21215-0036

within 24 hours a To the Funerel [ 9

Registrar

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier PRIYANKA

NELLORI M.D

29c. License number P18616

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NELLORI 900 CATON AVENIUE PRIYANKA

6 Could not be determined

3 Suicide

29a. Certifier

4 Homicide

(Check only one)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

			State Amend Item 29c p	te of Maryland / Eer dvr G842 4	Department of F	lealth and Menta Death	al Hygiene	005	14132
	Physicia /Medic		1. Decedent's Name (First, Middle, Last)	Sr	nall			2005	3. Time of Death 2:10 A-M
}	Examin	er	4a. Facility Name (If not institution, give street a 4015 20 4h	Place	Temp	r Location of Death		Prince (	georges
	Funeral Director		5. Social Security Number 6. Sex 1 ☐ M 2  Usual Residence of Decedent	7. Age (In yrs. last bir	Yrs. If Under 1 Year Months Days		te of Birth onth, Day, Year) Irch 4, 19	9. Birthp Cour	place (State or Foreign
	Maryland 9-f ehow ified at	tor	10a. State 10b. County	rgcs Te	n or Location  mole  -	tills		1	0d. Inside City Limits 1 ☐ Yes 2 No
	th with the 23e or 28e	Funeral Director	10e. Street and Number 40/5 20 4h P/	ace	10f. Zip Code	748	10g. Cit	izen of What Cour	itry?
920	72 hours after death with the Maryland natural', or terms 23e or 28e-f ehow Jical Enaminer must be codiffed at	by	1 Never Married 25% Married 1 [	Is Decedent Ever in U.S. ned Forces? ]Yes 2⊠No 'es, Give ar or Dates:	13. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☒ No	lispanic Origin? (Specify Y. an, Mexican, Puerto Rican, Specify:	es or No- etc.)	14. Race - Americ Black, White, Specify:	
21215-0036	within 72 ho ene. than "naturi he Medical I	Completed	15. Decedent's Education (Specify only highest grade complete comp	bleted)	Decedent's Usual Occup (Give kind of work done life. DO NOT use retired	during most of working	_	ind of Business/Ind	•
Maryland 2	2 should be filed within and Mental Hygiene. Is marked other than "sumatic event, the Me	To Be Co	17. Father's Name (First, Middle, Last) Nathan	Hendersor		18. Mother's Name (First Mary			
	s 1 and 2 of Health a item 27 is other trai		19a. Informant's Name/Relationship (Type, Pr.  A VIS ∠ Small- F  20a. Method of Disposition  1   B Burial 2 □ Cremation 3 □ Remove	tusband 4	. Mailing Address (Street  015 20 YM  Disposition (Name of ry, crematory or other place)	and Number or Aural Rout  ACC Temple  Date	e Number, City of	Varyland	Code) 20748 wm, State
Baltimore,	permit. Pages Department of I Important: If it eny injury or o				n Memoria Go		5 CK	irksville	, Virginia
	Physician /Medical		23a. Part1. Enter the disease, or complication shock, or heart failure. List only one coul Immediate Cause (Final disease or condition resulting in death)	s that caused the death. Do not see on each line.	not after the mode of dair			onker. All	proximate Interval Between Onset and Death
8760,	icate be executed by physician and physician and sthe burial-transit	cal Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c.	Due to (or as a consequence					
.O. Box 6	death certific e attending p ed for use as	Physician/Medical	in the past 12 months?	es, outcome of pregnancy ]Live birth 2 ☐ Fetal death ]Pregnant at time of death ]Unknown	3 ☐Ectopic pregnancy 5 ☐ Other (specify) _	,		23d. Date of delive Month	ery Day Year
rds, P	sign d be	by	Part II. Other significant conditions contributi	ng to death but not resulting ir	n the underlying cause giv	en in Part I. 23		use contribute to th	ne cause of death? ably 4 🗷 Unknown
Vital Record	The law ate has b page 2 sl	Completed					ia. Was an autopsy performed?	prior to cor death?	psy findings available inpletion of cause of
f Vita	Physician: Th this certificate ral director, pag	To Be	25. Was case referred to medical examiner?  1 □ Yes 2 ☑ No Hospita	l: 1 ☐ Inpatient 2 ☐ ER/Ou	tpatient 3□ DOA Oth	26. Place of Death <i>Chec</i> er: 4 Nursing Home 5		6 ∏Other (Specifi	()
ion of	sing After fune		27. Manner of Death  1 M Natural 5 Pending 2 Accident investigation	Date of Injury 28b. 1	Time of 28c. Injury Wor		escribe how injur		,
Division	tal or Attenders after deatles Birector: ed in by the	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28€	. Place of Injury - At home, fa building, etc. (Specify)	rm, street, factory, office	28f. Lo <i>Ci</i>	cation (Street an ty or Town, State	d Number or Rura )	l Route Number,
	To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by	edical	(Check only 2 Medical Examiner: O	To the best of my knowledge in the basis of examination and d manner stated.	e, death occurred at the tind d/or investigation, in my o	ne, date and place, and du pinion, death occurred at th	e to the cause(s) ne time, date and	and manner as st place, and due to	ated. the cause(s)
	To the h within 24 To the R complete	Σ	29b. Signature and title or confier	1	29c. Licens 010	1053922 (VA	0/	te signed (Month, 1	
	5		30. Name and address of person who complete Mehrdad Ebadi-Teh			res Av., Al		ia, VA.	22311
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Signature	to di a	ė .			

DHMH 17 Rev 1/2001

ORIGINAL

			For State Registrar		Sta	ate of M	aryland		rtment			and M	lental Hy	giene Reg. No.	000	and the second	133
П	Physici	an	Decedent's Name	e (First, Middle	, Last)	11-		P:					2. Date of De Month 04	ath 20	2005	r	of Death
	/Medic		4a. Facility Name (I	f pot institution	Dive street	40 and number	ر ک	////	4b. City.	Town, or	Location of	of Death		- 1	2005 County of De	133	SO ""
	LAdiiiii	C1	Shady G							kvi					Montgo		
	Funeral Director		5. Social Security N 593-51-1	361	6. Sex XXM 2		ge (In yrs. Ia 88	st birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birl (Month, Da 11-18	th ly, Year) 3-19]	9. B	irthplace (Stat Country) Kor	te or Foreign 'ea
	land ow		Usual Residence of 10a. State	10b. County			10c. City,	Town or Lo	cation								City Limits
	Mary -f sh	ţ	MD	Montgo	omery		Ga	ithers	burg							1 ☑ Y	'es 2 □ No
	h with the 13a or 284 st be not	Funeral Director	10e. Street and Nur 961 Clop		#B-1				10f. Zip		20878				zen of What (	Country?	
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or items 23a or 28e-f show many injury or other traumatic evant, the Medical Examination and once.	þ	11. Marital Status 1 Never Marri 3 Widowed		ed 1 [	as Decedent med Forces Yes 20 Yes, Give ear or Dates:	?		Vas Deced f Yes, spec		ispanic Ori in, Mexican Specify:		ecify Yes or No Rican, etc.)	•	14. Race - Ar Black, WI Specify:	_	,
21215-0036	within 72 ho ene. than "natur	Completed	Elementary/Seco		t grade com		5+)		lent's Usual kind of work DO NOT us aploye	k done d e retired	ation during mos. ()	t of worki	ing	16b. Ki	nd of Busines	s/Industry	
<u>q</u>	i Hygi I Hygi othar ant,	Be Co	unknown 17. Father's Name		Last)						18. Mothe	er's Name	e (First, Middle,	Maiden	Sumame)		
/lar	uuld be Menta arked	To B	unobtai	nable							un	obta	inable				
, Maryland	and 2 sho salth and in 27 ia mu		19a. Informant's Na Kwang S										al Route Number Gaither				
Baltimore,	ges 1 it of He if itan or oth		20a. Method of Disp 1 Burial 2		3 □Remov	al from State	Ce.	ace of Dispo metery, cren	natory or ot	her plac			Date 2005			or Town, State	
Ħ	it. Pa rtmen rtant: njury		* 4 ☐ Donation 21. Signature of Fu				CII		. Name and				2-2005	bel	tsvill	e m	
Ba	Departing Important any in any		Styll	w Lola	nam		100382	2 9	Rapp I 933 Gi	une: st	ral & Ave S	Cre ilve	mation r Sprin	ig MI	ices 20910	-	
			23a. Part1. Enter the shock, or hea Immediate Cause (	rt failure. List	complication only one cau	is that cause ise on each	ine.	. Do not ent	er the mode	of dyin	g, such as	cardiac o	or respiratory a	rrest,		Approxin Interval 8 Onset ar	Between
	Pnysician /Medical		disease or condition resulting in death)	n	a	A Chi Due to (or a	s a conseque	ence of):	rep	rel	17	M	1077/20	rge	2	2 de	245
V	Examiner and transit	Examiner	Sequentially list con any, teading to an cause. Enter Unde Cause (Disease or that initiated events resulting in death) I	i	b	Hy.	s a conseque	ence of	ids	en)	ra					5 4	£44 S
8760,	certificate be executed iding physician and ise as the burial-transit		,		d	D08 (0 (0) a	s a consequi	ence on).									
O. Box 6	death e atter	Physician/Medical	IF FEMALE: 23b. Was decedend in the past 12 1 ☐ Yes 2 ☐ 9 ☐ Unknown	months? ☐No	11	yes, outcom Live birth Pregnant a	2 Fetal	death 3	Ectopic pre Other (spe						23d. Date of o	lelivery Day	Year
rds, P.	w requires that the been signed by th should be detache	by	Part II. Other signif	icant conditio	ns contribut	ing to death	but not resul	iting in the u	nderlying ca	use give	en in Part I.		23e. Did t	,		to the cause of	
I Record	The law ate has b page 2 sl	Completed											24a. Was autor perfo 1 - Yes		24b. Were prior to death	autopsy findin o completion o	gs available of cause of
of Vital	Physician: Th this certificate ral director, pag	Be	25. Was case refer examiner?		Hospita	al:				Othe	or:		(Check only o				
on of	ling After fune	lon: To	1 Yes 2 2 27. Manner of Death 1 Natural	h 5 □ Pendin	28	a. Date of Inj (Month, D	urv :	R/Outpatien 28b. Time of Injury		Bc. Injury Work	4∐Nu ∕at		me 5 Resident			pecify)	
Division	or Attan ifter deat Diractor: in by the	Certification:	2 Accident 3 Suicide 4 Homicide	investig 6 ☐ Could r determ	not be	e. Place of Ir building, e	njury - At hor atc. <i>(Specify)</i>	ne, farm, str			163 201		28f. Location (: City or To			Rural Route N	lumber,
_	e Hospital 24 hours a Eunaral I etely filled	edical C	29a. Certifier (Check only one)	1 Certifyin 2 Medical	Examiner: (	To the bes	of examination	vledge, death on and/or in	occurred a vestigation,	at the tim in my op	ne, date an pinion, dea	d place, a	and due to the ed at the time,	cause(s) date and	and manner place, and d	as stated. ue to the caus	e(s)
	To the within 2 To the complet	Me	29b. Signature and	title of certifier		_			29c.	License	e number			29d. Dat	e signed (Mo	nth, Day, Year	r)
)			1	500	ca	in	7		D	00	12/0	033	3	Apr	121	200	55
	- 1		30. Name and addr	19 K.	who complete	S, M	0	23a) (Type,	Print)	rea	910	Az	3 Jenue :	Silve	SPYN	20 9. Mai	906 yland
	Sta Registr		31. Date filed (Mon	APR 2	6 200	32. Refis	trar's Signati	The A	park	0				_	00		

		_	State Registrar	State of Maryland /				ealth a Death		R	eg. No.	005	14134
	Physici	an	1. Decedent's Name (First, Middle, Last) Elnora Lorraine	Spell						Date of Deat Month Dril 2:	Day		3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give s				Clin	Location of		PIII Z.	4c. 0	2005 County of Death Lince Ge	
	Funeral Director		5. Social Security Number 6. Sex 160 22 2611	7. Age (In yrs. last b	oirthday)_ Yrs.	If Under Months	1 Year Days	If Under 2 Hours	Min.	Date of Birth (Month, Day,	, Year)		nplace (State or Foreign untry)
	yland		10a. State 10b. County	10c. City, To	wn or Loc	ation							10d. Inside City Limits
	8e-f si	Funeral Director	Maryland Prince	George's		Clin							1 ☐ Yes 2 ☐ No
	with the	Dire	10e. Street and Number 6401 Horsesh	oe Road		10f. Zip	Code 2073:	5		1	-	zen of What Co	•
	death	nera		2. Was Decedent Ever in U.S. Armed Forces?	13. W				in? (Specif	y Yes or No-		nited S 14. Race - Amer Black, White	ncan Indian,
36	d within 72 hours after death with the Maryland jeene. Ir than "natural", or Hems 23e or 28e-f show It e Mouteal Examiner in unt be mailfied at	by Fu	1 ☐ Never Married 2 ☐ Married  \$\times \times \tim	1 ☐ Yes 2 ☐ ¶ Mo If Yes, Give Year or Dates:	j	□ Yes			1 40110 1110	M11, 010.)		Specify:	White
2-00	72 hour	ted t	15. Decedent's Educ (Specify only highest grade	ation 16	a. Decede	ent's Usua	al Occupa	ition	of working		16b. Kin	nd of Business/l	
121	within 7 ene. than "r	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)				uring most	or working				
d 2	filed v Hygie othar t		17. Father's Name (First, Middle, Last)		HOM	emake	er	18. Mother	's Name (F	irst, Middle, i		Own Hom Sumame)	e
/lan	should be and Mental and Mental as marked o	То Ве	Clarence Sorg					Kar	coline	e Wilko	р		
Maryland 21215-0036	01 00 00 00		19a. Informant's Name/Relationship (Type Charles G. Wentz			-						r Town, State, Z Marylan	. ,
ē,	s 1 and 2 f Health itam 27 other tru		20a. Method of Disposition	20b. Place								cation - City or	
Baltimore,	Pages ment of I ant: If its ury or o		1 Burial 2 □ Cremation 3 □ Re 1 □ Donation 5 □ Other (Specify)	moval from State	rrec	tion	Сеп	eterv	,	C	lint	ton, Mar	rvland
Balt	permit. Page Department of Important: If any injury or ance.		21. Signature of Funeral Service Liganse	7	22.	Name ar	nd Addres	s of Facility	Lee F	uneral	. Hor	me, Inc	563301d
			23a Part 1. Enter the disease, or complice	mod 957 rations that caused the death. D	o not ente	r the mod	laira le of dying	J. Ferr	y Kd., cardiac or re	Clint espiratory arr	est,	Maryla	nd 20735 Approximate
Ų	Physician		shock, or heart failure. List only on Immediate Cause (Final disease or condition	e cause on each line.	J 8:	TL3	VE	He	sut,	Funla	N		Interval Between Onset and Death
8760,	The law requires that the death certificate be executed and the has been signed by the attending physician and be detached for use as the burial-transit	dicai Examiner	Sequentially list conditions, it any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence)  Due to (or as a consequence)	ee of):	len	111						gan
.O. Box 6	that the death certifica led by the attending ph detached for use as th	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	Bc. If yes, outcome of pregnancy  1 Live birth 2 Fetal dea  4 Pregnant at time of death 9 Unknown		Ectopic pi Other (sp			1000		2	23d. Date of deli Month	ivery Day Year
rds, P	quires that n signed b uld be deta	by	Part II. Other significant conditions con	1 1 1 1 1	g in the un		ause give			23e. Did to		1	the cause of death?
ecords,	e faw requir has been si je 2 should l	Completed	Fre	MIN HON						24a. Was a autops	sy	prior to d	topsy findings available completion of cause of
Vital R		e Cor	25. Was case referred to medical					00 DI	15 4 4		2/2/No	death? 1 □ Yes	2 No
f Vii	ys diis	To Be	examiner? .	ospital: Japatient 2 ER/	Outpatient	3 DC	Othe	or:		Check only or 5 □ Resid		6 □Other (Spec	cify)
n of	ding Ph h. After th funeral		27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year) 28b	D. Time of Injury		28c. Injun Work		1	d. Describe h	ow injur	y occurred	
Division	Attener deat actor:	Certification;	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, building, etc. (Specify)	, farm, stre	M eet, factor		Yes 2□N		Location (S City or Tow			ral Route Number,
	Hospita 4 hours Funerel ely filled	edical C	29a. Certifier (Check only one)	ician: To the best of my knowled ler: On the basis of examination and manner stated.	dge, death and/or inv	occurred	at the tim	ne, date and pinion, deat	d place, and th occurred	d due to the c at the time, c	ause(s) date and	and manner as I place, and due	stated. to the cause(s)
	To tha He within 24 To the Fe complete	Me	29b. Signature and title of corthol			29	License	number		2	29d. Dat	te signed (Monti	h, Day, Year)
•	(		20 Alama and at least	mulated source of death (the con-	a) (Time :	Deint\	D1.	175/			7	ujos	
	N		Name and ad ss of reson who co	mpleted cause of death (Item 23)	UN (Type, I	-rint) クノアル	NA	1 4/	05 =	TI WE	TAK	worker,	MD 20145
	St Regist	ate rar	31. Date filed (Month, Day, Year)	mpleted cause of death (Item 23:	15	Spa	de						

	1-	For State Registrar			Cert	rtment of Frificate of			Reg. No		Li	135
		Decedent's Name (First, Middle, Li	.ast)	-		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		2. Date of D		·	3. Tim	e of Death
hysician		Louise E.	Sylvester		*			Month April	23 23	y 2005	ar	:40 A
/Medical xaminer	4a. F	Facility Name (If not institution, gi				4b. City, Town, c	or Location of Dea			. County of D		.40 A
.xammer		Bradford Oaks N		<u> </u>			linton				George	S
neral	5. S	ocial Security Number 6.	Sex 7. Age			If Under 1 Year	If Under 24 Hrs				Birthplace (Sta	
ector		577 24 1894	1□ M 2√√ 82	2	Yrs.	Months Days	Hours Min	Aug 3			ashingt	
>	_	ual Residence of Decedent  State 10b. County		10a Cin	. Taum as lass	4:						
show ad at				TOG. City	, Town or Loca						1	e City Limits ′es 2 □ No
benutitied benutitied Director	Ma		George's		C.	linton						XX
Dir	10e.	Street and Number	lewood Ave			10f. Zip Code	_		10g. Cit	tizen of What	Country?	
rai, or liams 23a or 28a-1 sho Examirer must be multired at by Funeral Director			12. Was Decedent B	Francis III	6 40.144	2073		N	Uni	ted St		
natural, or Itams dical Examination	11. !	Marital Status  XX Never Married 2 Married	Armed Forces?	ever in U.:	5. 13. W	as Decedent of F Yes, specify Cub	lispanic Origin? (9 an, Mexican, Puer	to Rican, etc.)	0-		merican Indiar /hite, etc.	
by F	•	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	<b>T</b> O	10	☐ Yes 2 No	Specify:			Specify:	White	
ed		15. Decedent's E	Education		16a, Decede	nt's Usual Occur	nation		16h K	ind of Busine		
		(Specify only highest gi	rade completed)		(Give ki life. DC	ind of work done O NOT use retired	during most of wo	rking	100.11	and or Edonic	od in loadiny	
la marked othar than aumatic evant, the M To Be Comp	- E	lementary/Secondary (0-12)	College (1-4or 5	+)	Secret				DC	Govern	mont	
ant.	17. i	Father's Name (First, Middle, Las					18. Mother's Na	me (First, Middle			ment	
		Edwin Frank Sy	lvester				Helen	Hupp				
mat T		a. Informant's Name/Relationship	(Type, Print)	-	19b. Mailing	Address (Street	and Number or R		ber. City o	or Town, State	e. Zip Code)	
5	I	Betty Beard (Si	ster)			Ramblewo		C11 .				
othar tra	-	. Method of Disposition		20b. PI	lace of Disposit	tion (Name of		Clinton		cation - City	or Town, State	,
y or	.	1 Nurial 2 □ Cremation 3 ( 4 □ Donation 5 □ Other (Spec			-	itory or other plac						
<u>10</u>	-	Signature of Funeral Service Lice		Lec	dar Hil	L Cemete	erv Apri ess of FacilityLe	129.200	5 B	mo Tro	d, Mar	Tand
Important: If Itam 2 any injury or othar once.								- I ULICI C	T 11.0	me , THC	0000	
	1/	Marin X. 14	a de mor	Mer	2 A1	exandria	a Ferry I	d Clan	ton	MI) 20	725	714
	2 8	Davis J. A.	molications that caused	the death	AL	exandria	a Ferry I	d, Clin	ton,	MD 20	735	
		a. Phrt. Enter the disease, or cor shock, or heart failure. List only	ry one cause on each lin	the death	Do not enter	the mode of dyir	Ferry I	d, Clin	ton, arrest,	MD 20	735 Approxi	nate Between
ician	Imm	nediate Cause (Final ease or condition	ARTELIO	the death	Do not enter	the mode of dyir	a Ferry I	d, Clin	ton, arrest,	MD 20	735 Approxi	nate Between
ician dical	Imm	nediate Cause (Final	ry one cause on each lin	the death	Do not enter	the mode of dyir	Ferry I	d, Clin	ton, arrest,	MD 20	735 Approxi	nate Between
cian lical iner	Imm dise resu	snock, or near rature. List one mediate Cause (Final ease or condition ulting in death)	Due to (or as a	the death ne.	Do not enter	the mode of dyir	Ferry I	d, Clin	ton, arrest,	MD 20	735 Approxi	nate Between
cian ical iner	Imm dise resu	snock, or neart rature. List one mediate Cause (Final ease or condition ulting in death)  quentially list conditions, my, teading to immediate isse. Enter Underlying use (Disease or injury	ARTELIO Due to (or as a	the death ne.	Do not enter	the mode of dyir	Ferry I	d, Clin	ton, arrest,	MD 20	735 Approxi	nate Between
ian ical ner	Imm dise resu	snock, or neart failure. List one nediate Cause (Final ease or condition ulting in death)	Due to (or as a	the death ne. a conseque	. Do not enter usence of):	the mode of dyir	Ferry I	d, Clin	ton, arrest,	MD 20	735 Approxi	nate Between
Examiner	Imm dise resu	snock, or near rature. List one mediate Cause (Final ease or condition ulting in death)  quentially list conditions, my, reading to mineciate isse. Enter Underlying use (Disease or injury trinitated events	Due to (or as a Due to (or a) Due to (or	the death ne. a conseque	. Do not enter usence of):	the mode of dyir	Ferry I	d, Clin	ton, arrest,	MD 20	735 Approxi	nate Between
e burral-transit au la	Sequence of the sequence of th	snock, or near rature. List one mediate Cause (Final ease or condition ulting in death)  quentially list conditions, my, reading to mineciate isse. Enter Underlying use (Disease or injury trinitated events	Due to (or as a c.	the death ne. a conseque	. Do not enter usence of):	the mode of dyir	Ferry I	d, Clin	ton, arrest,	MD 20	735 Approxi	nate Between
e burial-transit and leading cal Examiner	Sequence of the sequence of th	mediate Cause (Final ease or condition ulting in death)  quentially list conditions, riy, reading to immediate size. Enter Underlying use (Disease or injury t initiated events ulting in death) Last	Due to (or as a c. Due to (or as a d.	the death the death the.	Do not enter  Lence of):  Lence of):	the mode of dyir	Ferry I	d, Clin	ton, arrest.	MD 20	Approxi	nate Between
e burial-transit au le la	Sequence of the sequence of th	shock, or heart rature. List one mediate Cause (Final ease or condition ulting in death)  quentially list conditions, my, teading to immediate ise. Enter Underlying ise (Disease or injury initiated events ulting in death) Last	Due to (or as a d	the deather.  consequence a co	Do not enter  Lence of):  Lence of):  Lence of):	the mode of dyir	a Ferry I	d, Clin	ton, arrest.	MD 20	Approxi	nate Between
e burial-transit au le la	Sequence of the sequence of th	shock, or heart rature. List one mediate Cause (Final ease or condition ulting in death)  quentially list conditions, inv, leading to immediate use. Enter Underlying use (Disease or injury trinitiated events ulting in death) Last	Due to (or as a b.  Due to (or as a b.  Due to (or as a c.)  Due to (or as a c.)  Due to (or as a c.)	the deather.  consequence a co	Do not enter  Lence of):  Lence of):  Lence of):	exendris the mode of dyir	a Ferry I	d, Clin	ton, arrest.	MD 20	Approxi	nate Between od Death
detached for use as the burial-transit  a logic  b hysician/Medical Examiner	Sequence of the sequence of th	snock, or near rature. List one mediate Cause (Final ease or condition ulting in death)  quentially list conditions, my, teading to immediate size. Enter Underlying isse (Disease or injury tinitiated events ulting in death) Last  FEMALE:  . Was decedent pregnant in the past 12 months?  1  Yes 2 Mo 9 Unknown	Due to (or as a d	the death	Do not enter  Junce of):  Junce of):  Junce of):  Junce of):  Junce of):	the mode of dyir	a Ferry I	id, Clin	ton, arrest.	MD 20	Approxi	mate Between de Death Year
be detached for use as the burial-transit  a point by Physician/Medical Examiner	Sequit discount that results IF F 23b	mediate Cause (Final ease or condition mediate Cause (Final ease or condition ulting in death)  quentially list conditions, my, leading to immediate use. Enter Underlying se (Disease or injury tinitiated events ulting in death) Last  EEMALE:  b. Was decedent pregnant in the past 12 months?  1  yes 2 % No	Due to (or as a d	the death	Do not enter  Junce of):  Junce of):  Junce of):  Junce of):  Junce of):	the mode of dyir	a Ferry I	d, Clim c or respiratory:	ton, arrest.	MD 20	Approxi	year
be detached for use as the burial-transit  a point by Physician/Medical Examiner	Sequit discount that results IF F 23b	snock, or near rature. List one mediate Cause (Final ease or condition ulting in death)  quentially list conditions, my, teading to immediate size. Enter Underlying isse (Disease or injury tinitiated events ulting in death) Last  FEMALE:  . Was decedent pregnant in the past 12 months?  1  Yes 2 Mo 9 Unknown	Due to (or as a d	the death	Do not enter  Junce of):  Junce of):  Junce of):  Junce of):  Junce of):	the mode of dyir	a Ferry I	c or respiratory:	tobacco u	23d. Date of Month use contribute	Approxi- Interval Onset a Onse	Year
2 should be detached for use as the burial-transit  a point a	Sequit discount that results IF F 23b	snock, or near rature. List one mediate Cause (Final ease or condition ulting in death)  quentially list conditions, my, teading to immediate size. Enter Underlying isse (Disease or injury tinitiated events ulting in death) Last  FEMALE:  . Was decedent pregnant in the past 12 months?  1  Yes 2 Mo 9 Unknown	Due to (or as a d	the death	Do not enter  Junce of):  Junce of):  Junce of):  Junce of):  Junce of):	the mode of dyir	a Ferry I	23e. Did	tobacco u	23d. Date of Month use contribute No 3	Approxi- Interval Onset a Onse	Year  Unknown
2 should be detached for use as the burial-transit  a point a	Sequit discount that results IF F 23b	snock, or near rature. List one mediate Cause (Final ease or condition ulting in death)  quentially list conditions, my, teading to immediate size. Enter Underlying isse (Disease or injury tinitiated events ulting in death) Last  FEMALE:  . Was decedent pregnant in the past 12 months?  1  Yes 2 Mo 9 Unknown	Due to (or as a d	the death	Do not enter  Junce of):  Junce of):  Junce of):  Junce of):  Junce of):	the mode of dyir	a Ferry I	23e. Did	tohacco u	23d. Date of Month  use contribute  No 3   24b. Were prior	Approxi- Interval Onset a Onse	Year  Unknown
as been signed by the attending physician and 2 should be detached for use as the burial-transit and a property of the propert	Sequence of the sequence of th	snock, or near rature. List one mediate Cause (Final ease or condition ulting in death)  quentially list conditions, my, teading to immediate size. Enter Underlying isse (Disease or injury tinitiated events ulting in death) Last  FEMALE:  . Was decedent pregnant in the past 12 months?  1  Yes 2 Mo 9 Unknown	Due to (or as a d	the death	Do not enter  Junce of):  Junce of):  Junce of):  Junce of):  Junce of):	the mode of dyir  CAA  actopic pregnancy Other (specify)	ren in Part I.	23e. Did	tobacco u Yes 2	23d. Date of Month  use contribute  No 3   24b. Were prior	Approximately and the cause probably 4 autopsy finding to completion of the cause probably autopsy finding to cause probably autopsy finding to cause probably autopsy finding	Year Unknown
certificate has been signed by the attending physician and rector, page 2 should be detached for use as the burial-transit of prices.  Be Completed by Physician/Medical Examiner	Immidiserest Sequencest Ferrorest IFF 23b Part	mediate Cause (Final ease or condition ulting in death)  quentially list conditions, my, leading to immediate size. Enter Underlying use (Disease or injury initiated events ulting in death) Last  FEMALE:  . Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 Unknown  Unknown  Was case referred to medical examiner?  1 Yes 2 No	Due to (or as a d	the deather.  the deather.  a consequence a	Do not enter  Lence of):  Lenc	the mode of dyir  CAA  actopic pregnancy Other (specify)  derlying cause giv	ren in Part I.  26. Place of Deler: 48 Nursing H	23e. Did 1   24a. Was auto	tobacco u Yes 2 s an ppsy ormed? 22 No one)	23d. Date of Month  24b. Were prior death	Approximately and the cause Probably 4 autopsy finding to completion 19 autops 2 No	Year Unknown
The Completed by Physician/Medical Examiner	Immudiserest Sequification and	mediate Cause (Final ease or condition mediate) asses or condition ulting in death)  quentially list conditions, my, leading to immediate isse. Enter Underlying isse (Disease or injury tinitiated events ulting in death) Last  FEMALE:  . Was decedent pregnant in the past 12 months?  1  Yes 2 KNo 9 Unknown  III. Other significant conditions  Was case referred to medical examiner?	Due to (or as a d	the deather.  the deather.  a consequence a	Do not enter  Lence of):  Lenc	the mode of dyir  CAA  actopic pregnancy Other (specify)  Jerlying cause give	ren in Part I.  26. Place of Deler: 4 Nursing H	23e. Did 1   24a. Was auto perf 1   Yes ath (Check only to control only to con	tobacco u Yes 2 s an popy ormed? 22 No one) idence	23d. Date of Month  24b. Ware prior death 1 1 Y	Approximately and the cause Probably 4 autopsy finding to completion 19 autops 2 No	Year Unknown
In the certificate has been signed by the attending priyablan and the prival-transit of	Immidiserest Sequinal Caucathat rest IF F 23b Part	mediate Cause (Final ease or conditions ulting in death)  quentially list conditions.  my, leading to immediate isse. Enter Underlying isse (Disease or injury initiated events ulting in death) Last  FEMALE:  D. Was decedent pregnant in the past 12 months?  1   Yes 2   No   9   Unknown  C. II. Other significant conditions  Was case referred to medical examiner?  1   Yes 2   No   No   No   No   No   No   No	Due to (or as a b.  Due to (or as a b.  Due to (or as a c.  Due to (or as a c.)  Due to (or a	the deather.  the deather.  a consequence a	Do not enter  Lence of):  Lenc	the mode of dyir  CAA  actopic pregnancy Other (specify)  Jerlying cause give	ren in Part I.  26. Place of Deler: 48 Nursing Hyat	23e. Did 1   24a. Wata auto perfit   1   Yes ath (Check only)	tobacco u Yes 2 s an popy ormed? 22 No one) idence	23d. Date of Month  24b. Ware prior death 1 1 Y	Approximately and the cause Probably 4 autopsy finding to completion 19 autops 2 No	Year Unknown
the fine certificate has been signed by the attending physician and the funeral director, page 2 should be detached for use as the burial-transit and process as the funeral director, page 2 should be detached for use as the burial-transit and process as the funeral director. To Be Completed by Physician/Medical Examiner	Immidiserest Sequencest IFF 23b Part 25.	mediate Cause (Final ease or conditions ulting in death)  quentially list conditions, inv. leading to immediate see. Enter Underlying see (Disease or injury tinitiated events ulting in death) Last  FEMALE:  D. Was decedent pregnant in the past 12 months?  1	Due to (or as a b.  Due to (or as a c.  Due to (or as a c.)  Due to (or	the deather.  the deather.  a consequence a	Do not enter  Junce of):  Junce of	the mode of dyir  CAA  actopic pregnancy Other (specify)  Jerlying cause giv  actopic pregnancy Other (specify)  28c. Injur Wor M 1	ren in Part I.  26. Place of Deler: 4 Nursing H	23e. Did 1   24a. Wata auto perfit   1   Yes ath (Check only)	tobacco u Yes 2 s an posy ormed? 22 No one) idence how injui	23d. Date of Month  23d. Date of Month  24b. Ware prior death 1 Y  6 Other (S)  y occurred	Approximately and the cause Probably 4 autopsy finding to completion of the cause (Pecify)	Year Unknown
buractor: After this certificate has been signed by the attending physician and burial-transit by the funeral director, page 2 should be detached for use as the burial-transit burial-tra	Immidiserest Sequencest IFF 23b Part 25.	mediate Cause (Final ease or conditions ulting in death)  quentially list conditions, my, leading to immediate size. Enter Underlying see (Disease or injury tinitiated events ulting in death) Last  FEMALE:  D. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9  Unknown  III. Other significant conditions  Was case referred to medical examiner?  1  Yes 2 No Manner of Death 1 Natural 5  Pending investigation of the province of the provi	Due to (or as a d. Due to (or as	the death re.  Substitute death re.  Substit	Do not enter  Lence of):  Lenc	ctopic pregnancy Other (specify)  Jerlying cause give  3 DOA  28c. Injur Wor M 1 Dot, factory, office	ren in Part I.  26. Place of Deler: 42 Nursing Hyat k? Yes 2 \( \) No	23e. Did  1 24a. War auto perf 1 Yes  28d. Describe  28f. Location City or To	tobacco u Yes 2 s an psy orned? 22 No one) idence how injuri	23d. Date of Month  24b. Were prior death 1 Y occurred  d Number or	Approximate Approx	Year Unknown
filled in by the funeral director, page 2 should be detached for use as the burial-transit of programment in the funeral director, page 2 should be detached for use as the burial-transit of programment in the funeral director, page 2 should be detached for use as the burial-transit of programment in the function of t	Immidiserest Sequencest IF F 23b Part 25.	mediate Cause (Final ease or conditions ulting in death)  quentially list conditions, my, leading to immediate see. Enter Underlying see (Disease or injury tinitiated events ulting in death) Last  FEMALE:  D. Was decedent pregnant in the past 12 months?  1	Due to (or as a b.  Due to (or as a c.  Due to (or as a d.  23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown  contributing to death but to contributing to death but 28a. Date of Injur (Month, Day building, etc.)	the death he.  Substitute of pregnar a conseque a conseque a conseque a conseque a conseque a conseque time of de but not result time of de conseque time of de conseq	Do not enter  Lence of):  Lenc	the mode of dyir  CAA  Cotopic pregnancy Other (specify)  Jerlying cause giv  3 DOA Oth  28c. Injur Wor M 1 Dot, factory, office	ren in Part I.  26. Place of Deler: 42 Nursing Hyat k? Yes 2 \( \sum \) No	23e. Did  1 24a. War auto perf 1 Yes  28f. Location City or To	tobacco u Yes 2 s an opsy ormed? 22 No one) idence how injur	23d. Date of Month  23d. Date of Month  24b. Ware prior death 1 Y 6 Other (S y occurred	Approximate Approx	Year  Year  Unknown  gs available  r cause of
ely filled in by the funeral director, page 2 should be detached for use as the burial-transit of page 3 should be detached for use as the burial-transit of page 3 should be detached for use as the burial-transit of page 3 should be detached for use as the burial-transit of page 3 should be detached for use 3 sho	Immidiserest Sequencest Ferrorest IF F 23b Part 25. 1	mediate Cause (Final ease or conditions ulting in death)  quentially list conditions.  my, leading to immediate size. Enter Underlying see (Disease or injury initiated events ulting in death) Last  EMALE:  D. Was decedent pregnant in the past 12 months?  1	Due to (or as a d. Due to (or as	the deather.  the deather.  a consequence a	Do not enter  Lence of):  Lenc	the mode of dying cause growther (specify)  3 DOA 28c. Injury Wor M 1 Dot, factory, office stigation, in my office control of the control of	ren in Part I.  26. Place of Deler: 48 Nursing Hyat k? Yes 2 \( \subseteq No	23e. Did  1 24a. War auto perf 1 Yes  28f. Location City or To	tobacco u Yes 2 s an opsy ormed? 22 No one) idence how injui (Street an wn, State cause(s), date and	23d. Date of Month  23d. Date of Month  24b. Ware prior death  24b. Ware prior death  3 Date of Month  24b. Ware prior death  4 No 3 Date of Month	Approximate Approx	Year  Year  Unknown  gs available in cause of
ely filled in by the funeral director, page 2 should be detached for use as the burial-transit of page 2 should be detached for use as the burial-transit of page 2 should be detached for use as the burial-transit of page 2 should be detached for use as the burial-transit of page 2 should be detached for use as the burial-transit of page 2 should be detached for use as the burial-transit of page 2 should be detached for use as the burial-transit of page 2 should be detached for use as the burial-transit of page 2 should be detached for use as the burial-transit of page 2 should be detached for use as the burial-transit of page 2 should be detached for use as the burial-transit of page 2 should be detached for use as the burial-transit of page 2 should be detached for use as the burial-transit of page 2 should be detached for use as the burial-transit of page 2 should be detached for use as the burial-transit of page 2 should be detached for use as the burial-transit of page 2 should be detached for use as the burial-transit of page 2 should be detached for use as the burial-transit of page 2 should be detached for use as the burial-transit of page 3 should be detached for use as the burial-transit of page 3 should be detached for use as the burial-transit of page 3 should be detached for use as the burial-transit of page 3 should be detached for use as the burial-transit of page 3 should be detached for use as the burial-transit of page 3 should be detached for use 3 shou	Immidiserest Sequencest Ferrorest IF F 23b Part 25. 1	mediate Cause (Final ease or conditions need as cause (Final ease or condition ulting in death)  quentially list conditions, my, teading to immediate use. Enter Underlying isse. Enter Underlying isse (Disease or injury initiated events ulting in death) Last  FEMALE:  Was decedent pregnant in the past 12 months? 1   Yes 2 Mo	Due to (or as a b.  Due to (or as a b.  Due to (or as a c.  Due to (or as a c.)  Due to (or a	the deather.  the deather.  a consequence a	Do not enter  Lence of):  Lenc	the mode of dying cause give the factory, office the triple of the factory, office the coursed at the timestigation, in my of the cause give the course of t	ren in Part I.  26. Place of Deler: 48 Nursing Hyat k? Yes 2 No	23e. Did  23e. Did  1	tobacco u Yes 2 s an psy ormed? 2 S No one) idence how injui (Street an iwn, State c cause(s) date and	23d. Date of Month  23d. Date of Month  23d. Date of Month  24b. Ware prior death  1	Approximate Approx	Year  Year  Unknown  gs available in cause of
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit of page 3 should be detached for use as the burial-transit of page 3 should be detached for use	Immidiserest Sequencest Ferrorest IF F 23b Part 25. 1	mediate Cause (Final ease or conditions ulting in death)  quentially list conditions.  my, leading to immediate size. Enter Underlying see (Disease or injury initiated events ulting in death) Last  EMALE:  D. Was decedent pregnant in the past 12 months?  1	Due to (or as a b.  Due to (or as a b.  Due to (or as a c.  Due to (or as a c.)  Due to (or a	the deather.  the deather.  a consequence a	Do not enter  Lence of):  Lenc	the mode of dying cause growther (specify)  3 DOA 28c. Injury Wor M 1 Dot, factory, office stigation, in my office control of the control of	ren in Part I.  26. Place of Deler: 48 Nursing Hyat k? Yes 2 No	23e. Did  23e. Did  1	tobacco u Yes 2 s an psy ormed? 2 S No one) idence how injui (Street an iwn, State c cause(s) date and	23d. Date of Month  23d. Date of Month  24b. Ware prior death  24b. Ware prior death  3 Date of Month  24b. Ware prior death  4 No 3 Date of Month	Approximate Approx	Year  Year  Unknown  gs available in cause of
filled in by the funeral director, page 2 should be detached for use as the burial-transit of programment in the funeral director, page 2 should be detached for use as the burial-transit of programment in the funeral director, page 2 should be detached for use as the burial-transit of programment in the function of t	Immidiserest Sequencest IFF 23b Part 25.1	mediate Cause (Final ease or conditions or condition ulting in death)  quentially list conditions, my, leading to immediate isse. Enter Underlying isse (Disease or injury initiated events ulting in death) Last  FEMALE:  . Was decedent pregnant in the past 12 months?  1	Due to (or as a b.  Due to (or as a c.  Due to (or as a c.  Due to (or as a c.)  Due to (or a	the death he.  Substitute death he.  Substit	Do not enter  Lence of):  Lenc	cotopic pregnancy Other (specify)  Jertying cause give  3 DOA  28c. Injur Wor M 1  stigation, in my o  29c. Licens D 185	ren in Part I.  26. Place of De ler: 48 Nursing H y at k? Yes 2 \( \text{No} \)  The me, date and place in pinion, death occurse number 45	23e. Did  1 24a. War auto perf 1 Yes  28f. Location City or To	tobacco u Yes 2 s an psy ormed? 22 No one) idence how injuri	23d. Date of Month  23d. Date of Month  24b. Were prior death 1 1 Y  6 Other (S)  y occurred  d Number or  place, and of  te signed (Month)	Approximate Approx	Year  Year  Unknown  gs available of cause of
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit of process.  Medical Certification; To Be Completed by Physician/Medical Examiner	Immodiserest Sequencest IFF 23b Part 25.1	mediate Cause (Final ease or conditions) mediate Cause (Final ease or condition) ulting in death)  quentially list conditions, my, teading to immediate use. Enter Underlying use (Disease or injury tinitiated events ulting in death) Last  FEMALE:  Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown  Unknown  Was case referred to medical examiner? 1   Yes 2   No Manner of Death 1   Natural 2   Accident 3   Suicide 4   Homicide  Medical Exa  1. Certifier (Check only one)  3. Signature and title of certifier	Due to (or as a b.  Due to (or as a c.  Due to (or as a c.  Due to (or as a c.)  Due to (or a	the deather.  the deather.  the deather.  a consequence a	Do not enter  Lience of):  Lien	ctopic pregnancy Other (specify)  Berlying cause grv  3 DOA Oth 28c. Injury Wor M 1 D  ot, factory, office  cocurred at the tin stigation, in my of  29c. Licens D 185 CENTRE	ren in Part I.  26. Place of Deler: 48 Nursing Hyat k? Yes 2 No	23e. Did  1 24a. War auto perf 1 Yes  28f. Location City or To	tobacco u Yes 2 s an psy ormed? 22 No one) idence how injuri	23d. Date of Month  23d. Date of Month  24b. Were prior death 1 1 Y  6 Other (S)  y occurred  d Number or  place, and of  te signed (Month)	Approximate Approx	Year  Year  Unknown  gs available  crumber,  e(s)

			For State Registrar	State of Ma			tment of H		and M	ental Hy	giene	05		36
Phy	/sicia	n	1. Decedent's Name (First, Middle, Las		Conchu	1,				2. Date of De		2005 <sup>Year</sup>	3. Time of D	
	ledica amine		4a. Facility Name (If not institution, give	George A.	Sancilu	-	4b. City, Town, or	r Location o	of Death	APRIL	1	2005 ounty of Deatl	5:53P.	М
E.Xc	attilite		HARBOR HOSPITAL CE				BALTIMOR					N/A	,	
Fune Direc			5. Social Security Number 217 54 8937 6. Security Number 10 Security Number 11 Security N		(In yrs. last birth 55 Y	rs.	If Under 1 Year Months Days	If Under Hours	24 Hrs. Min,	8. Date of Bir (Month, Da Jan. 1	th av, Year) 0, 19	9. Birth Con Mai	nplace (State or untry) Cyland	Foreign
yland	Ħ	1	10a. State 10b. County		10c. City, Town	or Loca	ation						10d. Inside City	Limits
e Mar		ctor	Maryland N/A		Balt:	imo	re						1 ☐ Yes	2 🗌 No
with th	200	Funeral Directo	10e. Street and Number				10f. Zip Code	225				S.	untry?	
death Trs 23	TIME	erai	4218 Audrey Av	12. Was Decedent E	ver in U.S.	13. W			gin? (Spe	cify Yes or No		I. Race - Amer	ican Indian,	
Dattimore, intarylating Z   Z   23-0030 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or frams 23a or 28a-1 show	EXSTRING	ρ́.	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1    Yes 2   No lif Yes, Give Year or Dates:			as Decedent of H Yes, specify Cuba ☐ Yes 2 ☑ No	Specify:	i, Puèrto I	Rican, etc.)		Black, White		
72 h	rice.	Completed	15. Decedent's Ed (Specify only highest grad	ucation de completed)	16a. C	Decede Give k	nt's Usual Occup ind of work done of NOT use retired	ation during mos	t of worki	ng		of Business/I lian	industry	
d withir giene.	N W	dmo	Elementary/Secondary (0-12)	College (1-4or 5-	-) Me	eat	cutter	1)				ot. of	Army	
e filed al Hyg	vant,	BeC	17. Father's Name (First, Middle, Last)						,	(First, Middle	, Maiden S		,	
ylaric ould be fift Mental Hy arkad oth	atica	Lo Lo		e Sanchuk						availa				
and 2 sh ealth and m 27 Is m	nar fraum		19a. Informant's Name/Relationship (7 William Hurst /		42.	18	Address (Street Audrey A	venue		Baltin	nore,	Maryla	nd 2122	5
Iges 1 If ite	or of		20a. Method of Disposition 1 ⊈Burial 2 ☐ Cremation 3 ☐		1		tion (Name of atory or other place			ate		ation - City or		د.
altimor mit. Pages spartment of portant: If it	injury		<ul><li>4 □ Donation 5 □ Other (Specify</li><li>21. Signature of Funeral Service Licen.</li></ul>		Cedar		1 Cemete			2005		•	Marylar ce, P.A.	
Deg E	any it		Janna Ms	rangen	with		001 Ritch							
			23a. Part1. Enter the disease, or congressions, or heart failure. List only	lications that caused one cause on each line	the death. Do no	_							Approximate Interval Betw	veen
Proysic			Immediate Cause (Final disease or condition resulting in death)	a. HYPERTENS								SEASE	Onset and De	eath
/Medi Exami			Tooding in dealin)	Due to (or as a	consequence of	f):						1		
3		Jer	Sequentially list conditions, if any, seating to immediate cause. Enter Underlying Cause (Disease or injury	b. — Due to (or as a	consequence of	i):								
) cuted	transil	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c										
ate be exerting	burial		resulting in death) Last	Due to (or as a	consequence of	f):								
oo/ ificate g phys	as the	edicai		d							- 10			
S, F.O. BOX 08/00, cs that the death certificate be executed igned by the attending physician and	ached for use	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome c 1□Live birth 2 4□Pregnant at t 9□Unknown	2 ☐ Fetal death		Ectopic pregnancy Other (specify)	,			23	d. Date of deli Month	•	ear
S, T	oe deta	by Pi	Part II. Other significant conditions co	ontributing to death bu	t not resulting in	the und	derlying cause giv	en in Part I		23e. Did	tobacco use	e contribute to	the cause of de	ath?
v requires	should	ted	DIABETES M	ELLITUS	-					10	Yes 2	No 3□Pro	obably 4 💢 r	nknown
The law ate has b	page 2	Completed								24a. Was auto perf 1 \( \text{Yes}		24b. Were au prior to death?	topsy findings a completion of ca 2 \( \text{No} \)	vailable use of
	director.	) Be	25. Was case referred to medical examiner?	Hospital:	- Mana		Oth			(Check only				
<b>=</b> 2 = 3.	0	 7	27. Manner of Death	28a. Date of Injun	y 28b. Ti	me of	3□ DOA 28c. injur	y at		me 5 ☐ Res 28d. Describe		Other (Spec	cify)	
ath. or: After	un et	atlo	1 ☐Natural 5 ☐ Pending 2 ☐ Accident investigation		Year) Inj	jury		k? Yes 2□	No					
DIVISION OF To the Hospital or Attending P. within 24 hours after death. To the Funaral Director: After the	ed in by t	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inju building, etc		m, stree	et, factory, office		1		(Street and own, State)	Number or Ru	ral Route Numb	er,
e Hospi 24 hou e Funai	letely fii	edical	29a. Certifier 1 Certifying Ph (Check only one) 2X Medical Exam	ysician: To the best o liner: On the basis of and manner stat	examination and	death Vor inve	occurred at the tinestigation, in my o	ne, date an pinion, dea	d place, a th occurr	and due to the ed at the time	cause(s) a , date and p	and manner as place, and due	stated. to the cause(s)	
To th within To th	comp	Me	29b. Signature and title of certifier				29c. Licens	e number			29d. Date	signed (Mont)	Day, Year)	
		1	I and	2 '			OCME				APRIL	21,200	)5	
Ct	1		30. Name and address of person who dana RUBIO MD.	completed cause of de	oath (Item 23a) (T	Гуре, Р		Popp (	Z+w-	.+ n_1		WOOD-2	1 10	1001
**	Stat	te	31. Date filed (Month, Day, Year)	32. Pegistra	r's Signature	S.	TTT 1	r GIIII Y	orre6	er pal	timor	e, Mar	yland 2	1201
	gistra		APR 2 6 2	005 Buen	r's Signature	Sport	W.							
DHMH 17 B	ev 1/20	ſΩ1												

	,	For State Registrar	State o	f Maryland		artment of I				giene Reg. No.	005	1413	7
Dhamini		Decedent's Name (First, Middle,     )	Last)		,		-		2. Date of Dea		Vear	3. Time of Dea	ith
Physicia /Medic		LICLIAN S	TEVEY	VSON					April	19'	2005	10:44 A	• M
Examin	er	4a. Facility Name (If not institution, Grace Lodge	give street and nur	mber)		4b. City, Town, Ba1	or Location timor			4c. C	ounty of Death	1	
Funeral Director		219 07 3324	6. Sex 1 □ M 2 🔏 F	7. Age (In yrs. las	t birthday) Yrs.	If Under 1 Year Months Days		24 Hrs. Min.	8. Date of Birt Month, Day March	17,19	9. Birth Con Ma	place (State or Foi intry) ryland	reign
and		Usual Residence of Decedent  10a. State 10b. County		10c. City,	Town or Lo	cation					1	10d. Inside City Lir	mits
Mary fied	ō	Maryland Anne	Arunde1	G	len Bı	ırnie						1 ☐ Yes 2 🗓	
death with the Maryland ms 23a or 28a-f show	Director	10e. Street and Number	AI under		LCII D	10f. Zip Code				10g. Citize	en of What Co	intry?	
23a o	aiD	1605 Bedford	Road			21	1061			U	J.S.		
ems ems	Funerai	11. Marital Status	12. Was Dece Armed Fo	edent Ever in U.S.	13. \	Was Decedent of	Hispanic Or can, Mexica	igin? (Sp	ecify Yes or No- Rican, etc.)	. 14	4. Race - Amer Black, White		
s afte	by Fu	1 Never Married 2 Marrie	ed 1 ☐ Yes If Yes, Giv	2 ( <b>X</b> No ∕e		1 ☐ Yes 2 🕱 No			, , , , , , ,		Specify: Wh		
turai'		3 ■Widowed 4 ■ Divorced	Year or D		16a Decer	dent's Usual Occu	nation			16h Kind	d of Business/l	ndusta	_
in 72	plet	(Specify only highest	grade completed)		(Give	kind of work done DO NOT use retire	during mos	st of work	ing				
d with giene ar tha	Completed	Elementary/Secondary (0-12) (not available)	College (1	1-40( 5+)	Mach	niníst				Nava	al Ship	Yard	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. I be partment of Health and Mental Hygiene.  By injury or other traumatic avent, the Marylan Examiner must be notified at one.	To Be C	17. Father's Name (First, Middle, La Jam	ast) nes Carney	у			18. Moth	er's Name E11a	e (First, Middle, n		<sub>umame)</sub> vailabl	e)	
shou and M smar sumat	-	19a. Informant's Name/Relationshi				ng Address (Stree							
l and 2 Health Im 27 I		James Tuminell	o / son	20h Blac		Bedford sition (Name of	Road		en Burn				
ages 1 to tr : If ite or of		20a. Method of Disposition 1 DXBurial 2 Cremation 3		State	netery, cren	natory or other pla Cemetery					ation - City or 1	own, State n. Maryla	nd
iit. Pa artmer ortant injury in		<ul> <li>4 □ Donation 5 □ Other (Special Signature of Funeral Service Lieuward)</li> </ul>		1111		2. Name and Addr	1	•	/2005 once Fin			ce, F.A.	illu
Departi Departi import any ir		1 Jecome	Fram	usent	//							yland 212	25
1		23a. Part. Enter the disease, or shock, or heart failure. List of	omplications that converge one cause	aused the death.	Do not ent	er the mona of dy	ing, such as	cardiac	or respiratory ar	rest,		Approximate Interval Between	1
Physician		Immediate Cause (Final disease or condition	1/2	SUINA	TON	4 /1	164					Onset and Beath	111
/Medical Examiner		resulting in death)	Aue to	(or as a consequer	nce of):	1						2 link	2
LAGIIIIII	_	Sequentially list conditions,	b/ Duoto	(or as a consequer	m,	177						1111	-
nsit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Ede to	(or as a consequer	nce or):								
al-trai	xar	that initiated events resulting in death) Last	c Due to	(or as a consequer	nce of):								
cate be executed physicien and the burial-transit	dlcal		d										
ng ph as th	Medi	IF FEMALE:											
ath ce ttendii or use	an/I	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live b	come of pregnanc pirth 2 Petal de	eath 3	Ectopic pregnanc	cy .			23	d. Date of deli Month	very Day Year	
The law requires that the death certificate be executed the has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	Physiclan/Me	1 ☐ Yes 2 █ No 9 ☐ Unknown	4□Pregn 9□Unkno	nant at time of deal own	th 5□	Other (specify) _					WORLD	Day 16a:	
that the by detact		Part II. Other significant condition	is contributing to de	eath but not resulti	ing in the ur	nderlying caușe gi	ven in Part	l.	23e. Did to	bacco use	e contribute to	the cause of death	?
aw requires that the s been signed by the s should be detach	d by	CHRONIC ATM	CIAZ F	13A1L	LATI	ion			1 D Y	es 2 <b>X</b>	No 3□Pro	bably 4 Unkno	own
s bee	ompleted		. , . , ,						24a. Was		24b. Were au	opsy findings avail	able
rsician: The law s certificate has b lirector, page 2 sl	lmo								autop perfor	med?	prior to c death? 1 🗌 Yes	ompletion of cause 22 No	ot
sian: ertifica ctor, p	Be C	25. Was case referred to medical examiner?					26. Plac	e of Deat	Check only o				
Physician: rthis certificaral director,	은	1 ☐ Yes 2 ☑ No		the state of the s	VOutpatien	" 3LI DOA		ursing Ho	me 5 Resid		Ther (Spec	Assisted Living	
ding F h. After funera	tlon;	27. Manner of Death  1 KNatural 5 Pending 2 Accident investiga		of Injury th, Day Year)	8b. Time of Injury	Wo	ıryat ork? ∃Yes 2.⊑	No	28d. Describe h	iow injury	occurred		
Atten deat ctor: y the	fica	3 Suicide 6 Could no	ot be 290 Place	of Injury - At hom-	e, farm, str	-			28f. Location (S	Street and	Number or Au	ral Route Number,	_
tal or selter selter ai Dire	Certification;	4 Homicide	buildi	ng, etc. (Specity)					City or Tow	m, State)			
To the Hospital or Attending Physician: The I within 24 hours eiter death.  To the Funeral Director: Affer this certificate ha completely filled in by the funeral director, page	edical	29a. Certifier 1 Certifying (Check only 2 Medical E.	Physician: To the xaminer: On the ba and mani	best of my knowle asis of examination ner stated.	edge, death n and/or inv	n occurred at the t vestigation, in my	me, date ar opinion, dea	nd place, ath occur	and due to the deed at the time,	cause(s) a date and p	nd manner as place, and due	stated. to the cause(s)	
To th within To th compl	Me	29b. Signature and title oncertifier	1			29c. Licen	se number			29d. Date	signed (Month	, Day, Year)	
		1/1/10/19	1/7	TEMOII	19	))(	103	70		4010	11/9	,2005	
8		30. Name and address of person w	no completed caus	se of death (Item 2	(3a) (Type,	Print)	n.t	321	On	Mas	Mus	(MM)	7
Sta Registr		31. Date filed (Month, Day, Year)  APR 2. 6	2005 37 R	legistrar's Signatur	Spe	de							
Registr	ar	APR 2 6	2005	EURI AS:	15	(h.def							

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760, <

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death Scholz Hildegard Smith April 17 2005 8:50 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Montgomery Bethesda Suburban Hospital If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Yea June 25, Birthplace (State or Foreign Country) Days Hours 1 ☐ M 2 🛱 F 78 579-64-6461 Yrs. June Ï926 Germany Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 TYes 2 No Silver Spring Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1400 East West Highway, #302 20910-6214 United States 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: White 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Anton Scholz Maria Watze 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1400 East West Highway, #302, Silver Spring, Maryland 20910 Grover C. Smith / Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) April 21, 20a Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Montgomery Crematorium, Inc. Bethesda, Maryland \* 4 ☐ Donation 5 ☐ Other (Specify) 2005 21. Signatura Funeral Service Picensee 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501 23a. Part1. Erfor the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death 5 days Aspiration Pneumonia Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Unions or injury Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💆 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an performed? Yes 2 No 1 ☐ Yes

**Physician** /Medical **Examiner** 

certificate be executed

The

Vital

ō

permit. Pages 1 and 2 should be file Department of Health and Mental Hy important: if item 27 is marked oth, any injury or other traumatic avent, 2008.

**Physician** 

/Medical

**Examiner** 

Director

Funeral

ģ

Completed

**Funeral** 

Director

r than "natural", or itams 23a or 28e-f show the Medical Examinar nust be notified at

e filed within 72 hours after death with Hygiene.

othar than "natural", or itams 236

Baltimore, Maryland 21215-0036

with the Maryland

the as ed by the a certificate After

Examiner Completed by Physician/Medical Be P To the Hospital or Attending P within 24 hours after death.

To the Funeral Director: After the completely filled in by the funera Certification:

IF FEMALE 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 9 Unknown

25. Was case referred to medical examiner? Hospital: 1 ☐ Yes 2X No 1 X Inpatient 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death

and manner stated

5 Pending investigation 6 Could not be

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

26. Place of Death (Check only one)

1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

1 X Natural

2 Accident

4 ☐ Homicide

3 Suicide

29a. Certifier

Medical

NVD

29c. License number

D58681

29d. Date signed (Month, Day, Year) April 17, 2005

diress of person who completed cause of death (Item 23a) (Type, Print)

8600 Old Georgetown Road, Bethesda, Maryland 20814 Judé Alexander, MD

State Registrar

DHMH 17 Rev 1/2001

32. Registrar's Sanature Berein Di Aparte

**ORIGINAL** 

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. Amend Item 23a per phys 8642 4-26-05 vt State of Maryland / Department of Health and Mental Hygiene 0 55 For State Registra-amend item #5&8 PER FH G843 Springstend Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Month **Physician** April 19, 2005 Jessie Mae Shaver 3:30 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Catonsville 626 Wallerson Road Baltimore If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) **Funeral** 6. Sex Birthplace (State or Foreign Country) 5243-36-8973 8. Date of Birth (Month, Day, Year) Months Days Hours Min. 1 M 2 STF Yrs Director 243-36-1917 88 Feb.<del>6,</del>1917 North Carolina Usual Residence of Decedent with the Maryland 10c. City. Town or Location 10d. Inside City Limits 10a, State 10b. County 28a-f show other treumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2X No Director Maryland Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Items 23e 626 Wallerson Road 21228 Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. and 1fem 27 is marked other then "naturel", or Items 23. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 📆 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 KNo Specify: White Specify: If Yes, Give Year or Dates: 3X Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be h and Mental ! Thomas A. Setzer Mary Jolly 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Ralph Shaver</u> Son 10 Long Meadow Road; Westford Mass. 01886 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Surial 2 ☐ Cremation 3 ☐ Removal from State ö permit. Page Department of Importent: If any injury or once. \* 4 □ Donation 5 □ Other (Specify) Arlington National May 12,2005 Arlington, Virginia 22. Name and Address of Facility Sterling Ashton Schwab Funeral Home, Inc. 736 Edmondson Avenue; Catonsville, MD 21228 21. Signature of Funeral Service Licensee hilstop 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Priysician CONGESTIVE HEART TAILUBRE /Medical Due to (or as a consequence of) Examiner TRIAL FIBRI Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner requires that the death certificate be executed the burial-transit Due to (or as a consequence of): Physiclan/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death 5 Other (specify) P.O. the 9 Unknown 9 Unknown þ signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ HYPERTENSION 1 Tes 2. No 3 Probably 4 Unknown Completed page 2 should DIABETEI MEllitus 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an The law autopsy ENDOMETRIAL CARCINOMA 2 No 1 Yes Vital Hospital or Attending Physician: director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 ☐ Nursing Home 5 residence 6 ☐ Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Tes Certification: To this o 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Mannet of Death 28b. Time of 28d. Describe how injury occurred Division Natural 5 Pending Injury death. 1 ☐ Yes 2 ☐ No 2 Accident investigation after death Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) by 4 T Homicide filled in within 24 hours at To the Funerel D completely filled i Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 12005 DO40369 will 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) COLUMBIA 100 PILWAY COLUMBIA NO 21045 8827 KANTHI WICKS MO, JHCP, 31. Date filed (Month, Bax) 32. Degistrar's Signature State 2005

DHMH 17 Rev 1/2001

Registrar

**ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death April Year Carolyn Mae Spriggs **Physician** 1:50 PM 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death County of Death Examiner Baltimore Daman han MOSPINAL Ballimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months, Days, Hours | Min. | Dec 2 1941 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** 1□M 2XF Months 63 Director 212-40-2842 MDUsual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County or 28e-f show rai', or itame 23e or 28e-f sh Examiner must be notified 1XYes 2 ☐ No MDN/A Baltimore Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5414 Purdue Avenue 21239 United States Completed by Funeral 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 24 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. Peges 1 end 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Black Yes, Give Specify: 3 Widowed 4 □ Divorced Year or Dates: 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Store rthan College (1-4or 5+) Elementary/Secondary (0-12) Laborer 8 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Samuel F. English is marked Mildred Douglas ٥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Florence English/Sis.InLaw 5414 Purdue Avenue, Balto. MD. 21239 Importent: If Item 27 is any injury or other tre-once. 20b. Place of Disposition (Name of cemetery, crematory or other place) Baltimore, Date 20c. Location - City or Town. State cemetery, crematory or other place)
Garrison Forest Apr 2005 Owings Mills, MD. 4 □ Donation 5 □ Other (Specify) 21. Signature Funeral Service Licensee Calvin L. Williams Funeral P.O. Box 11651 Balto. MD. 23a. Fart. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) PSIS **Physician** /Medical Due to (or as a consequence of): Examiner 5 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner sicien and burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 attending physicien by Physician/Medicai the as IF FEMALE use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 ☐Live birth 3 Ectopic pregnancy ŏ in the past 12 months? Month Dav 4☐Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown ģ signed Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? pe 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗷 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe Artery 1 ☐ Yes 2 🗷 No 2 🔀 No oronar 25. Was case referred medical examiner? or Attending Physicien: Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No in by the funeral dir this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification; Atter 5 Pending investigation 1 Natural death. 1 ☐ Yes 2 ☐ No 2 Accident efter death 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide To the Hospitei within 24 hours ento to the Funerei D filled 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

DHMH 17 Rev 1/2001

Maled

31. Date filed (Month, Day, Year)

Hassan

ORIGINAL

South

Baltimore, MD 21239

5601 Loch Raven Blud

32. Registrar's Signature

			State of Maryland / Department of Health an	•	_	7 5 7 5 8
			1- State Certificate of Death		Reg. No.	
	Physicia	an	Decedent's Name (First, Middle, Last)	2. Date of De	ath Day Year	3. Time of Death
	/Medic		Josephine Taylor Totter	Hpril.	21-2005	- 1040/ M
	Examin	er	4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of D		4c. County of Dea	th
			Levindale Hebrew Geriatric Ctr&Hospital Baltimo  5. Social Security Number   6. Sex   7. Age (In yrs. last birthday)   If Under 1 Year   If Under 24		th Q Riv	tholace /State or Ferniss
	Funeral Director			Vlin. (Month, Da	ly, Year) C 0/1910 NY	thplace (State or Foreign ountry)
	D		Usual Residence of Decedent	03/30	771910 NI	
	show	_	10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits 1 ☑ Yes 2 ☑ No
	8a-f	Director	MD Baltimore City Baltimore			
	a or a	Ē	10e. Street and Number 10f. Zip Code		10g. Citizen of What C	ountry?
	leath	Funeral	2434 W. Belvedere Avenue 21215  11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin	? (Specify Yes or No	USA - 14. Race - Am	erican Indian
(0	ifter of	표	Armed Forces? If Yes, specify Cuban, Mexican, P	uerto Rican, etc.)	1	te, etc.
8	raf, c	i by	3 ☑Widowed 4 ☐ Divorced If Yes, Give Year or Dates:		Specify: Wh:	te
ر ا	72 h	Completed	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of	working	16b. Kind of Business	/Industry
7	within	Id II	Elementary/Secondary (0-12) College (1-4or 5+)		Agricultur	e
d 2	flied within 72 hours after death with the Maryland Hygiona. Niter than "natural; or Items 23a or 28a-f show ant, the Maccel Examiner must be maiffed at		8 Food Inspector  17. Father's Name (First, Middle, Last) 18. Mother's	Name (First, Middle,	Maiden Sumame)	
an	ould be Mental arked o	To Be		Raynor	,	
Maryland 21215-0036	2 should and Men is marke aumatic	-	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number of	r Rural Route Numbe	er, City or Town, State,	Zip Code)
Ξ	1 and 2 Health a tem 27 is		Robert Totter/Son 275 11th Street Atla	antic Beac	ch, FL 3223	3
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if time 27 is marked other than "natural; or litems 23a or 28a-f show any injury or other traumatic event, the Marcial Examiner must be multified at office.		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place)	Date Apr 25	20c. Location - City or	Town, State
Ĕ	Pag ment ant: I		'4 □ Donation 5 □ Other (Specify) Chesapeake Crematory Inc		Beltsville,	Maryland
33	permit. Depart Import any in		21. Signature of Funeral Service Licensee  22. Name and Address of Facility  Cremation and Fune	eral Altern	natives	
	40240		222 Part 1 Enter the disease or complications that covered the death. Do not enter the great of this manth as an	es Drive H	Baltimore, M	aryland 2128% Approximate
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as car shock, or heart failure. List only one cause on each line.  Immediate Cause (Final	diac or respiratory at	rrest,	Interval Between Onset and Death
	Pnysician /Medical	H	disease or condition resulting in death)	ncho	1	1 Mes
	Examiner		Que to (or as a constraince of):	diso as	<b>4</b>	Tycas
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury			15
	cuted	Examiner	that initiated events			
760,	icate be executed physician and s the burial-transit		resulting in death) Last Due to (or as a consequence of):			
	cate b	dlcal	d			
9 ×	The law requires that the death certifical te has been signed by the attending phoage 2 should be detached for use as the	Physician/Med	IF FEMALE: 23c. If yes, outcome of pregnancy		224 Date of to	1
Вох	atten for u	clan	in the past 12 months?		23d. Date of de Month	Day Year
P.O.	Ihe d by the ached	hysl	1 Yes 2 No 9 Unknown 5 Other (specify)			
٠ <u>,</u>	w requires that been signed t should be det	y P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did to	obacco use contribute t	o the cause of death?
ğ	en sig	ed t	on regidemence.	_ 101	Yes 2□No 3□P	robably 4 Unknown
Vital Records,	has be ge 2 sho	Completed by	0	24a. Was		utopsy findings available completion of cause of
	10 -	Com			rmed? death?	
/ita	sicien: Th certificate rector, pag	Be (	examiner?	Death Check on o		
of \	Physicien: this certific ral director,	은	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other:		dence 6 Other (Spe	ecify)
	ling After fune	lon	27. Manner of Death  28a. Date of Injury  Natural 5 Pending  (Month, Day Year)    Natural 5 Pending   Pend	28d. Describe f	now injury occurred	
Division	Attending r death. Sctor: After oy the fune	ficat	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory office	28f. Location /5	Street and Number or R	ural Route Number
	after after Dire	Certification:	4 Homicide determined 288. Place of injury - At nome, farm, street, factory, office building, etc. (Specify)	City or Tov		siai riosto riamoor,
	To the Hospital or Attending Physicien: within 24 hours after death To the Funerel Director: After this certific completely filled in by the funeral director.		29a. Certifier  Certifying Physician: To the best of my knowledge, death occurred at the time, date and pi	lace, and due to the	cause(s) and manner a	s stated.
	he Ho in 24 he Fu pletel	edical	(Check only one)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death one)  and manner stated.			
	To T To t	Σ	29b. Signature and title of certifler 29c. License number		29d. Date signed (Moni	
1			Meyam (M) D44817		April-22	(-2005
	2		30. Name and address of person who completed cause of death (Item 23a) (Type, Print).  2 4 3 4 \( \times \) Education dere are:  31. Date filed (Month: Day Year)  APR 2 6 2005	Salhm	one lel.	2121
	Sta	te	31. Date filed (Month, Day/Year)  2. Registrar's Signature	, -	/ • •	
	Registr	ar	APR 2/6 2005 Keeper & Species			

State of Maryland / Department of Health and Mental Hygie (e) [] 5 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** Bessie L. Thomas 2005 10:20 EM. neri /Medical 4a. Fecility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Anne Arundel GICN Burnie North Arundel Hospita If Under 1 Year | If Under 24 Hrs. 5. Social Security Number (In yrs. last birthday) 85 Yrs. Birthplace (State or Foreign Country) **Funeral** Days Hours 1□M 2XF 108-26-3561 Yrs. Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or Items 23a or 28e-f show other treumatic event, it a Madical Examinar must be notified at MD Anne Arundel Glen Burnie 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? 142 Janelin Drive 21061 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian 1 Never Married 2 ☐ Married Maryland 21215-0036 1□ Yes 2No Specify: Black <u>م</u> Specify: 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) House Keeping House Keeping 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 12 should be f h and Mental } Robert R. Thomas Mary Murray 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 st. Department of Health and Important: If Item 27 ts.m. any injury or other traum 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Shirley M. Bunch/niece 142 Janelin Drive, Glen Burnie MD 21061 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition
1 □ Burian 2 A Cremetion 3 □ Removal from State
1 □ Donation 5 □ Other (Specify) 20c. Location - City or Town, State Chesapeake Cremation 4/22/05 Stevensville, MD 21. Signature of Funeral Service Licens 22. Name and Address of Facility Singleton Funeral Home P.A. M01364 1 Second Ave SW GLen Burnie MD 21061 hart . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Aspiration
Due to (o as a consequence of): Physician /Medical Examiner Cerebrounsa Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of) attending physician and for use as the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy 2 | Fetal death in the past 12 months?
1 ☐ Yes 2 No
9 ☐ Unknown Month Day Year 4☐ Pregnant at time of death 5 Other (specify) P.0. been signed by the s should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has all director, page 2 s autopsy 2 XNo 1 🗆 Yes 2 🗆 No 1□ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 1 ☐ Yes 2 No Medical Certification: To 2 ER/Outpatient 3 DOA completely filled in by the funeral 27. Manner of Death

1 XNatural

2 Accident 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending death. investigation 1 ☐ Yes 2 ☐ No or Attend efter death Director: / 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospitel o within 24 hours of To the Funerel Di 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number April 19, 2005 D027415 who completed cause of death (Item 23a) (Type, Print) Arundel North 32/Registrar's Signature 31. Date filed (Month, Day, Year) State APR 2 6 2005 Registrar

DHMH 17 Rev 1/2001

homas

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ( 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 2005 941 AM Elizabeth Carole Tracev /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** Chass Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Min. Months Days Hours 1 □ M 2 □ X E 220-40-8425 April 24. 1944 Maryland Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2√2 No Completed by Funeral Director Maryland Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21014 USA 1102 Red Pump Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🖾 No Specify: If Yes, Give Year or Dates: 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Priscilla Frances Ward Clarence Joseph Lynch, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1102 Red Pump Rd., Bel Air, Maryland 21014 Richard Calvin Tracey / Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ⊠Burial 2 □ Cremation 3 □ Removal from State <sup>1</sup> 4 □ Donation = 5 □ Other (Specify) Mt. Zion UMC Cemetery 4-23-05 Bel Air, Maryland 22 Name and Address of Facility Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part. Effect the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of): a

**Physician** /Medical **Examiner** The law requires that the death certificate be executed burial-transit Division of Vital Records, P.O. Box 68760, use as the Hospital or Attending Physician: after death. within 24 hours aft To the Funeral Di

**Funeral** 

Director

or 28a-f show

or itams 23a

Pagas 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. Int: If Itam 27 is marked other than "natural", or Itams 23.

Maryland 21215-0036

Baltimore,

other traumatic event, the Medical Exercities must be notified at

5 Department of Important: If any injury or once.

with the Maryland

THACEY

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 ♥ Unknown	23c. If yes, outcome of pregnancy  1  Live birth 2 Fetal death 3  Ectopic pregnancy  4  Pregnant at time of death 5  Other (specify)				23d. Date of delivery Month Day Year	
Part II. Other significant conditions	contributing to death but not res	sulting in the underlying o	cause given in Part I.	23e. Did tobacco	use contribute to the cause of death?  No 3 Probably 4 Unknown	
				24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?  1 Yes 2 No	
25. Was case referred to medical examiner?	26. Place of Death (Check only one)					
17 Yes 2 □ No	Hospital: 1 ☐ Inpatient 2	ER/Outpatient 3 Do	OA Other: 4 Nursing H	ome 5 Residence	6 ☐Other (Specify)	
27. Manner of Death 1 Natural 5 Pending 2 Accident investigation		28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28c. Injury at Work? 1 Yes 2 No			8d. Describe how injury occurred	
3 Suicide 6 Could not 4 Homicide determined	28e. Place of Injury - At h building, etc. (Speci	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			<ol> <li>Location (Street and Number or Rural Route Number, City or Town, State)</li> </ol>	
27. Manner of Death  1 Natural 2 Accident 3 Suicide 4 Homicide  29a. Certifier (Check only one)  27. Manner of Death 5 Pending investigativ determiner  5 Pending investigativ determiner	hysician: To the best of my known miner: On the basis of examination and manner stated.	owledge, death occurred ation and/or investigation	at the time, date and place n, in my opinion, death occu	, and due to the cause(s rred at the time, date an	) and manner as stated. d place, and due to the cause(s)	
29b. Signature and title of certifier  Bernaul Je	feller un s	WE 29	c. License number	29d. Da	ite signed (Month, Day, Year)	
30 Name and address of person with	completed cause of death (Ite	m 23a) (Type, Print) M. J.	7018 HOLA	BIRD AVE	BALTO, MEZIZ	

DHMH 17 Rev 1/2001

Registrar

31. Date filed (Month, Day, Year)

APR 2 6 2005

 $\gamma$ 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 115 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** Apri1 23, 2005 Marion D. Upton 2:00A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Shady Grove Adventist Hospital Rockville Montgomery If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 □ M 2 🕅 F Months Director 577-18-2994 90 1914 Canal Zone, Panama Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If Item 27 is marked other than "natural", or Items 23a or 28a-f ahow 10c. City, Town or Location 10a. State 10b. County Item 27 is marked other than "natural", or items 23a or 28a-4 ahow other traumatic event, the Maxical Examiner must be notified at 10d. Inside City Limits 1 Yes 2 No Director Maryland| Montgomery Bethesda 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7609 Chelton Road United States Completed by Funeral 20814 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: 3 Nidowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 2 Utilities Payroll Specialist 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ٥ John William Donnelly Edith Louise Cox 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If Item 27 is any injury or other trau David E. Upton/Son 7609 Chelton Road, Bethesda, Maryland 20b. Place of Disposition (Name of cometery, crematory or other place)
Montgomery 20a. Method of Disposition April 25, 20c. Location - City or Town, State 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 2005 Bethesda, Maryland Pumphrey Funeral Home/ 2757 Wisconsin Avenue \* 4 ☐ Donation 5 ☐ Other (Specify) Crematorium, Inc. 22. Name and Address of Facility Robert A.
Bethesda-Chevy Chase, Inc.
Bethesda, Maryland 20814-3 21. Signatur eral Service Listee Wisconsin Avenue 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician neumonia resulting in death) /Medical Due to (or as a consequence of): Examiner 2 heime Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury Examiner or Attending Physician: The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Be Completed by Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year Day 4 Pregnant at time of death 5 Other (specify) ed by the a P.0. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, been signe should be 1 Yes 2 4 To 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 □ No 1 🗌 Yes 2 2 N 1 Tyes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Impatient 2 ER/Outpatient 3 DOA 10 1 Yes 2 No After thi 28a. Date of Injury (Month, Day Year) 27 Manner of Death 28h Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 Watural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ģ 4 Homicide 1 🗄 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier April 23, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Shahyar Gharacholou, 9901 Medical Center Drive, Rockville, Maryland M.D.2005 Registrate Signature 31. Date filed (Month, Day, State FELLES. Registrar

		•	1 - For State Registrar	State of Maryland		ment of H			ene ) [	5 4145
ı	Physici		1. Decedent's Name (First, Middle, L	<sup>ast)</sup> VesseII	5			2. Date of Death Month	Day	3. Time of Death
	/Medic Examin		4e. Facility Name (If not institution, gi			//	Location of Deal		4c. County of	
	Funeral Director		5. Social Security Number 6. 217 · 18 · 9014  Usual Residence of Decedent	Sex 7. Age (In yrs. last		Under 1 Year onths Days	If Under 24 Hrs Hours Min		1910	Birthplace (State or Foreign
	e Maryland la-f show	ctor	10a, State 10b, County		Own or Location	MORE	-			10d. Inside City Limits 1 ☑ Yes 2 ☐ No
	ath with the 23a or 28 ust be no	ral Director	1900 E. Hof	FMAN St.	1	0f. Zip Code	2/2/3	10	eg. Citizen of Wh $oldsymbol{U}$	at Country?
5-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hyglene, item 27 is marked other than "natural; or itema 23s or 28a-f show other traumatic event, the Medical Examinat must be notified at	by Funeral	11. Marital Status  1 □ Naver Married 2 □ Married  3 ☑ Widowed 4 □ Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		Decedent of His s, specify Cubar Yes 2 No	spanic Origin? (S n, Mexican, Puer Specify:	Specify Yes or No- to Rican, etc.)		American Indian, White etc.  PLACK
21215-(	filed within 72 h Hygiene. ther than "natu int, the Medical	Completed	15. Decedent's I (Specify only highest g		6a. Decedent' (Give kind life. DO N	s Usual Occupa of work done d OT use retired;	luring most of wo	rking	6b. Kind of Busi	ness/industry  ATE
Maryland	should be filed of and Mental Hygie marked other umatic event, I	To Be C	17. Father's Name (First, Middle, Las LESTER D	XON			18. Mother's Na	me (First, Middle, M	laiden Sumame) TEWAK	
_	is 1 and 2 sho of Health and i item 27 is mu		19a. Informant's Name/Relationship  AUDKEY CARS	ON DAVBHTER	1500	E H	OFFMAI	vral Route Number, V St. B	City or Town, Si	
altimore,	Page nent o ant: If ary or		20a. Method of Disposition  1 Burial 2 Cremation 3  4 Donation 5 Other (Spec	- ceme	e of Disposition etery, cremator WUKE N	ry or other place	UETERY 4			IN ORE MARYLAND ENE FUNE MICHINE
Bal	permit. Departr Importa any inji		21. Signature of Funeral Service Lice	ha Lineal	4905	me and Addres	K ROAC	DAUTO,		NE FUNERMUTM. 21212
	Physician /Medical Examiner		shock, or heart failure. List onl Immediate Cause (Final disease or condition resulting in death)	a. Pulmonav Due to (or as a consequen	y en	e mode of dying  Tholise  Tholose	n	c or respiratory arre	st,	Approximate Interval Between Onset and Death  2 clays
8760,	sate be executed obtaining and the burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c.  Due to (or as a consequen  d.						
O. Box 6	The law requires that the death certifica ate has been signed by the attending phoage 2 should be detached for use as it	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 IDNo 9 □ Unknown	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 4 ☐ Pregnant at time of death 9 ☐ Unknown	ath 3 □Ecto	opic pregnancy er (specify)			23d. Date Month	
rds, P	w requires that been signed b should be deta	by	Part II. Other significant conditions	contributing to death but not resultin	ng in the under	ying cause give	on in Part I.	23e. Did toba		ute to the cause of death?
al Records,		Completed						24a. Was an autopsy perform 1 Yes 2	ed? pric	ore autopsy findings available or to completion of cause of ath?
of Vital	S =	To Be	25. Was case referred to medical examiner?  1  Yes 2 No	Hospital: 1 panpatient 2 □ ER	/Outpatient 3	□ DOA Othe		ath <i>(Check only on</i> e Home 5 ☐ Resider	<u></u>	(Specify)
Division o	tending leath. tor: After the fune	Certification;	27. Manne of Death  1	(Month, Day Year)	b. Time of Injury h, farm, street, t		at ? ∕es 2 □ No	28d. Describe how	eet and Number	or Rural Route Number,
Ō	Hospital 4 hours Funeral ely filled	Medical Cert	29a. Certifier 1 Certifying F	Physicien: To the best of my knowle	dge, death occ	urred at the tim gation, in my op	e, date and place	a, and due to the car	use(s) and mann	ner as stated. d due to the cause(s)
	To the Hos within 24 h To the Fur completely	Mec	29b. Signature and title of certific	halmopho, in	edical atom	29c. License	number		d. Date signed (	Month, Day, Year)
1	1		30. Name and address of person who		la) (Type, Print	ers low	ye,600 N	. Wolfe St,	Baltima	-e, MO 21287
	Sta Registr		31. Date filed (Month, Day, Year) APR 2 6 2	32 Registrar's Signature	9					

Shadrick G. Woah-Tee 05-02782 crn

> Physician /Medica Examine

**Funeral** Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Itams 23a or 28a-1 show any injury or other traumatic event, the Medical Exaction or invalible redifficial anones.

Pnysician /Medical **Examiner** 

Baltimore, Maryland 21215-0036

For Stata Registrar	State of Mar	-		t of Health e of Death		ientai Hy	Reg. No.	005	4 14
Decedent's Name (First, Middle, Last Shadrick	G.		Woah-T	'ee		2. Date of De Month	eath Day	Year 2005	3. Time of Dea
a. Facility Name (If not institution, give	street and number)		4b. City, 1	Town, or Location	of Death	April	4c.	County of Dea	
ohns Hopkins Bayv	iew Medical	Cente	r Bal	ltimore				N/A	
. Social Security Number 6. Se		In yrs. last birth			Min.	8. Date of Bi (Month, Da 1-1-	rth ay, Year) 67	C	thplace (State or Fo buntry) iberia
Isual Residence of Decedent  Oa. State  Md.  NA		0c. City, Town	orLocation Saltimore	e					10d. Inside City Li
Oe. Street and Number 6017 Arizona Aven	ue		10f. Zip	<sup>Code</sup> 21206			_	zen of What C	•
11. Marital Status  1 Never Married 2 Married	12. Was Decedent Eve Armed Forces? 1 ☐ Yes 2 No If Yes, Give	er in U.S.	13. Was Deced	lent of Hispanic Or offy Cuban, Mexica		ecify Yes or No Rican, etc.)	0-	14. Race - Ame Black, Whi	te, etc.
3 Widowed 4 Divorced  15. Decedent's Edu (Specify only highest grad	Year or Dates:		Decedent's Usua	al Occupation		ing	16b. Ki	nd of Business	lack /Industry
Elementary/Secondary (0-12)  12th grade	College (1-4or 5+)		lummer	se retired)			Rot	or Roo	ter
7. Father's Name (First, Middle, Last)	_ , ,					e (First, Middle	, Maiden		
Daiwor	Togbah		h-Tee		ngba			Nanlo	
19a. Informant's Name/Relationship ( $T_1$ ) ${ m Dr.JosephWoah-T}$		1	-	. Belved					
0a. Method of Disposition  1   Burial 2 □ Cremation 3 □ F  4 □ Donation 5 □ Other (Specify)		20b. Place of cometery Woah-	Disposition (Name), crematory or of	ne of ther place)		Date 5-05		cation - City or	
21. Signature of Funeral Service Licens				1					
De la due	w on	کی	22. Name and	d Address of Facil	lity	Bal	timor	re, Md. North A	21202
23a. Part1. Enter the disease, or comp shock, or heart failure. List only old disease or condition	lications that caused the cause on each line.	T I	22. Name and March of enter the mode	F.H. Ea.	st s cardiac	Bal 1101	timor E. N	re, Md.	21202
23a. Part1. Enter the disease, or comp shock, or heart failure. List only of mediate Cause (Final disease or condition resulting in death)	lications that caused the cause on each line.  a	consequence o	22. Name and March ot enter the mode Moul No.	F.H. Ea.	st s cardiac	Bal 1101 or respiratory a	timor E. N	re, Md.	21202 Ve. Approximate Interval Between
23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury)	lications that caused the cause on each line.	consequence o	22. Name and March ot enter the mode Moul No.	F.H. Ea.	st s cardiac	Bal 1101 or respiratory a	timor E. N	re, Md.	21202 Ve. Approximate Interval Between
23a. Part1. Enter the disease, or comp	lications that caused the cause on each line.  a	consequence o	22. Name and March ot enter the mode MOUND ft):	F.H. Ea.	st s cardiac	Bal 1101 or respiratory a	timor E. N	re, Md.	21202 Ve. Approximate Interval Between
23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	lications that caused the cause on each line.  a	consequence o	22. Name and March ot enter the mode MOUND ft):	d Address of Facil  F.H. Ea; e of dying, such as:	st s cardiac	Bal 1101 or respiratory a	E. N	re, Md.	21202 Ve. Approximate Interval Betweer Onset and Deatl
23a. Part1. Enter the disease, or comp shock, or heart failure. List only of immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, fany, leading to immediate cause. Enter Underlying Cause (Disease of injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1	b. Due to (or as a condition of the cond	consequence of conseq	22. Name and March of enter the mode of th	d Address of Facil  F.H. Ea: e of dying, such as:  () (	st s cardiac	Ba1 1101 or respiratory a	E. I	23d. Date of de Month	21202 Ve. Approximate Interval Betweer Onset and Deatl
23a. Part1. Enter the disease, or comp shock, or heart failure. List only of immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, fany, leading to immediate ause. Enter Underlying Cause (Disease or injury hat initiated events esuiting in death) Last  FFEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	b. Due to (or as a condition of the cond	consequence of conseq	22. Name and March of enter the mode of th	d Address of Facil  F.H. Ea: e of dying, such as:  () (	st s cardiac	Bal 1101 or respiratory a	timon E. Narrest,	23d. Date of de Month  Se contribute t  24b. Were a prior to death?	Approximate Interval Between Onset and Death Death Onset and D
23a. Part1. Enter the disease, or comp shock, or heart failure. List only of mmediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, any, leading to immediate ause. Enter Underfying Dause (Disease or injury hat initiated events esulting in death) Last  F FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  Part II. Other significant conditions c	Due to (or as a continuous description).	consequence of conseq	22. Name and March of enter the mode of th	egnancy ecify)  26. Place	st scardiac of the control of the co	Bal 1101 or respiratory a  EST  23e. Did 1 24a. Warautu puri	timon E. N  arrest,  tobacco u Yes 2	23d. Date of de Month  se contribute t  24b. Were a prior to	Approximate Interval Between Onset and Death Death Onset and D
23a. Part1. Enter the disease, or comp shock, or heart failure. List only of immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, fany, leading to immediate cause. Enter Underlying Cause (Disease or injury hat initiated events esuiting in death) Last  FFEMALE: 23b. Was decedent pregnant in the past 12 months?  1	ilications that caused the one cause on each line.  a	consequence of conseq	22. Name and March of enter the mode of th	egnancy escity)  26. Plac	st scardiac of CM	Bal 1101 or respiratory a  23e. Did 1 □  24a. Weas auto perf 1 □ × es h (Check only) me 5 □ Res	timon E. N arrest,  tobacco u Yes 2 San spry pormed? 2 No one) idence	23d. Date of de Month  Se contribute t  24b. Were a prior to death? 1 Le Yes	Approximate Interval Between Onset and Death Death Onset and D
23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown  Part II. Other significant conditions could be conditioned as a condition of the conditions of the	Due to (or as a composition of the course on each line).  a	consequence of conseq	22. Name and March ot enter the mode of the underlying calculations and the underlying calculations of	egnancy eachly)  26. Place	st scardiac of the scardiac of	Bal 1101 or respiratory at 23e. Did 1 1 24a. What autoperf 12 4a. What a	timon E. N arrest,  tobacco u Yes 2 San spry pormed? 2 No one) idence	23d. Date of de Month  Se contribute t  24b. Were a prior to death? 1 La Yes	Approximate Interval Between Onset and Death Death Onset and D

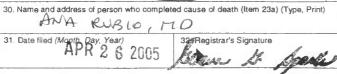
been signed by the attending physician and should be detached for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir

> State Registrar

RUBLO 31. Date filed (Manth Day, Year) APR 2 6 2005

29b. Signature and title of certifier



29c. License number

111 Penn Street

**OCME** 

29d. Date signed (Month, Day, Year)

April 21, 2005

Baltimore, Maryland 21201

		ĺ	For Stete Registrar	State of Maryla		artment of H			giene 005	14147
	Physici	an	1. Decedent's Name (First, Middle, I			4 1 1 1	2450	2. Date of Dea	ath Day Year	3. Time of Death
real	/Medic	al	SHIR 2 4a. Facility Name (If not institution, g		,		MER or Location of Dear	APP_12	23 200 4c. County of Dea	
	Camin	CI	Bon Secours Hos			Baltimo	re City			
	Funeral Director		222-16-3607	. Sex 7. Age (In yrs	. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min		v, Year) C	rthplace (State or Foreign Country)
	yland 10w		Usual Residence of Decedent  10a. State 10b. County		ity, Town or Lo					10d. Inside City Limits
	8a-f sl	Director	Md	В	altimor					1 ☐ Yes 2 🔏 No
	3a or 2		10e. Street and Number 2117 Dennison	Street		10f. Zip Code 21216			10g. Citizen of What C USA	Country?
36	be filed within 72 hours after death with the Maryland stal Hygiene. Id other than "natural", or Itams 23a or 28a-f show event. I're Medical Evanirat must be routlisd at	by Funerai	11. Marital Status  1 Never Married 2 Married	If Yes, Give A		Was Decedent of H f Yes, specify Cub		Specify Yes or No- to Rican, etc.)	14. Race - Arr Black, Wh	ite, etc.
00-9	2 hour	ted b	3 Widowed 4 Divorced  15. Decedent's		16a. Dece	dent's Usual Occur	pation		16b. Kind of Busines	
21215	e filed within 7: al Hygiene. I other than "n vent, Ir e Medi	Completed	(Specify only highest g	College (1-4or 5+)	life.	kind of work done DO NOT use retire nemaker	during most of wo	orking	domesti	1
Maryland 21215-0036	2 should be file and Mental Hy is marked othe raumatic event.	To Be C	17. Father's Name <i>(First, Middle, La</i> unknown	st)			18. Mother's Na unknow		Maiden Sumame)	
	es 1 and 2 should b of Health and Ment f itam 27 is marked r other traumatic e		19a. Informant's Name/Relationship Lizzie Linton (g						or, City or Town, State, Baltimore	
Baltimore,	O 0	13	20a. Method of Disposition  1X Burial 2 Cremation 3  4 Donation 5 Other (Spe	☐Removal from State	cemetery, crei	esition (Name of matory or other place 1d Cemet	ery 4-25	Date -05	20c. Location - City o Sykesville	
Balti	pernit. Pa Depurtmen Important: any injury		21. Signature of Funeral Service Lic	11 1	P.	Name and Address O. Box 1	95 Sykes	ight Fun ville, M	eralHome & d 21784	Chape1
			23a. Part1. Enter the disease, or co shock, or heart failure. List on	emplications that caused the dealy one cause on each line.	ath. Do not en	er the mode of dyi	ng, such as cardia	ic or respiratory ar	rest,	Approximate Interval Between
	Priysician /Medical		Immediate Cause (Final disease or condition resulting in death)			ERAL	PNYE	MONIA		Onset and Death  SDAYS
9	Examiner			Due to (or as a conse		STRNE	TIVE 21	1N4 D	ISEASE	HARMONA
7	ait sit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conse	quanto ut).					7/
0	be executed sician and burial-transit	Examiner	that initiated events resulting in death) Last	c. ARTERI Due to (or as a conse	<u>∂</u> 3 ∠ 2 equence of):	EROTIC	HEA	E, Di	SUASE	
8760,	icate be e physician s the buria	dical		d						
.O. Box 6	The law requires that the death certificate be executed ate has been signed by the attending physician and cage 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown	23c. If yes, outcome of preging 1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time of 9 ☐ Unknown	tal death 3	Ectopic pregnanc Other (specify)	у		23d. Date of d Month	elivery Day Year
<u>α</u>	ires that the de signed by the a l be detached	þ	Part II. Other significant conditions		esulting in the u	nderlying cause gr	ven in Part I.		obacco use contribute	to the cause of death?
core	w require been sig should b	ompieted	3CH120P					24a. Was		autopsy findings available
Vital Records,		Сотр	5/17 31	2ATERAZ	MAST	ECTUN	y	autop	sy prior to rmed? death?	completion of cause of
Vita	Physician: Th this certificate ral director, pag	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatient 2	TER/Outpation	2/7 DOA Ott		ath (Check only o	<i>ne)</i> dence 6 □Other (Sp	-c/(L)
n of	ing Phy Viter this uneral c	H	27. Manner of Death 1 Datural 5 Pending	28a. Date of Injury (Month, Day Year)	28b. Time o	f 28c. Inju			now injury occurred	өспу)
Division of	To the Hospital or Attanding I within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Certification;	2 Accident investigat 3 Suicide 6 Could no 4 Homicide determini	t be 290 Blood of Injury At	home, farm, st		]Yes 2∏No	28f. Location (S City or Tow	Street and Number or F	Rural Route Number,
٥	a Hospital or 24 hours afte a Funeral Dir etely filled in l		29a. Certifier 1 Certifying	Physicien: To the best of my kr	nowledge deat	h accurred at the t	rmo data and place	and due to the	councies and manner	os stated
	To the Hospital within 24 hours of To the Funeral completely filled	ledicai	(Check only 2 Medicel Ex	seminer: On the basis of examinand manner stated.	nation and/or in	vestigation, in my	opinion, death occ	urred at the time.	date and place, and du	ue to the cause(s)
	To tha within 2 To tha complete	Z	29b. Signature and title of certifier	safeta no	,	29c. Licen:	233 <i>00</i>		29d. Date signed (Mor	nth, Day, Year) 23 2005
	1		30. Name and address of person with SUD HIR	no completed cause of death (Ite	эт 23a) (Туре,	Print) Bo	N SELO	RE ST	EUSPITAL BALTO	MD.21223
* '%	Sta Regist		31. Date filed (Month, Day, Year)	32. Registrar's Sign	natura					

State of Maryland / Department of Health and Mental Hygien 2 1 5 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 1155 P M Lloyd William Woolford 2005 APPI 1 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner City Union Memorial Hospital Baltimore | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Feb. | 9. 7. Age (In yrs. last birthday) 5. Social Security Number 213–12–8566 9. Birthplace (State or Foreign **Funeral X** M 2□ F Maryland Director Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County in then "natural", or Items 23s or 28s-1 show the Medical Examiner must be notified at Owings Mills Md. Baltimore 1 Yes 2 No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21117 U.S.A. 102 Byway Rd. death Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 1 and 2 should be filed within 72 hours after. Health and Mental Hygiene. em 27 Is marked other then "natural", or Itel 1 Never Married 2 Married 1 ☐ Yes X No Baltimore, Maryland 21215-0036 White If Yes, Give Year or Dates: Specify: ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Mechanic Baltimore Transit Co 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) is marked Helen Marie Hinkhaus Joseph Franklin Woolford, Sr. 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 102 Byway Rd., Owings Mills, Md. 21117 : If item 27 la Thelma Woolford - Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20c. Location - City or Town, State Pages nent of t permit. Page Department of Important: If any injury or once. Reisterstown U.M. Ch. Cem. April 28,2005 Reisterstown, \* 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility

Eckhardt Funeral Chapel, P.A. 21. Signature of Puneral 21. Signature of Puneral Service Licenses

Eckhardt Funeral Unapel, F.a.

11605 Reisterstown Rd., Owings Mills, Md.

23a. Part. Enty the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death

O.

23a. Part. Enty the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death

O. 21117 Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) **Examiner** euttemia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physiclan/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) the 9☐ Unknown þ signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by should be 1 ☐ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an certificate 1 Yes or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 1 Yes 2 No 2 ER/Outpatient 3 DOA Medical Certification: To 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 1 ☑Natural 28c. injury at Work? 28d. Describe how injury occurred 28b. Time of After 5 Pending 1 ☐ Yes 2 ☐ No death 2 Accident investigation hours after death the 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours a
To the Funeral I
completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 1100611 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Share Miot Eart artima 31. Date filed (Month, Da Day, Year) 36 Registrar's Signature State 26

DHMH 17 Rev 1/2001

Registrar

2005

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 0 5

	2		For State Registrar	State of Ma		partment of leartificate of			1 L	15 14 149
			Decedent's Name (First, Middle, Landson L	est)		0111110410 01	Douth	2. Date of De	Reg. No. ath	3. Time of Death
	Physicia	an	_					APAIL 1	Q \ Day	Year
	/Medic		EDWARD W 4a. Fecility Name (If not institution, gir		<u> </u>	4b. City. Town.	or Location of Deatl		4c. County	of Death
	Examin	er	Northwest Hospit			Randal.			1	more County
	Funeral				(In yrs. last birthd			8. Date of Birt	th	Birthplace (State or Foreign Country)
	Funeral Director			13XIM 2□F 8	Ver	Months Days	Hours Min.	(Month, Da	y, Year)	Maryland
	D		Usual Residence of Decedent		<u> </u>			1.06. /	1710	riar y rand
	nylan how		10a. State 10b. County		10c. City, Town o	Location				10d. Inside City Limits
	Ma-f.s	cto	MD N/A		Baltimo	re				1√2 Yes 2 □ No
	th th	ire	10e. Street and Number			10f. Zip Code			10g. Citizen of	What Country?
	th wi	a	3821 Byfield Roa	ad		21207			US	A
	ems ems	Funeral Director	11. Marital Status	12. Was Decedent E Armed Forces?		<ol> <li>Was Decedent of I If Yes, specify Cub</li> </ol>	lispanic Origin? (S an, Mexican, Puert	pecify Yes or No to Rican, etc.)		ce - American Indian, ck, White, etc.
90	or It	y F.	1 Never Married 2 Married	1 ☐ Wes 2 ☐ N If Yes, Give		1 ☐ Yes 2√2 No	Specify:		Specif	
ë	within 72 hours after death with the Maryland ene. then "natural", or items 23s or 28s-f show the Modical Exemirer must be notified at	d by	3X Widowed 4 ☐ Divorced	Year or Dates:	1945					
7	"nat	Completed	15. Decedent's E (Specify only highest gi	ade completed)	(G	cedent's Usual Occup ive kind of work done e. DO NOT use retire	during most of wor	rking		Susiness/Industry
12	within	ᇤ	Elementary/Secondary (0-12)	College (1-4or 5-	-)	k Driver	<b>-</b> /			on Transfer
2	Hyginther Ther		17. Father's Name (First, Middle, Las	t)	Tru	ck blivel	18. Mother's Nar	ne (First, Middle,	and Sto	
au	ad be sed o	Be	John Hood Warfie				Helen I	/irginia	Ropp	
Maryland 21215-0036	hould Me mark matte	ဥ	19a. Informant's Name/Relationship	(Type, Print)	19b. M	ailing Address (Street				State, Zip Code)
S	id 2 s Ith ar 1th ar 27 is trau		Carol Blum (daug							,,
ē,	Hea Hea tem		20a. Method of Disposition	incer)	120b. Place of Di	35 Brueh1 sposition (Name of		Date MU,	21155 20c. Location	- City or Town, State
20	ages ant of t: # I		1 ☑ Burial 2 ☐ Cremation 3 l 14 ☐ Donation 5 ☐ Other \( Spec		1	crematory or other pla e Nationa		/22/05	Baltimo	owo MD
altimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, Ite Medical Exeminer must be notified at once.		21 Signature of Funeral Service/Lice		PGI CIMO	22. Name and Addre			rk Funer	ral Home
ä	Ped Ped Poep Ped		Xmo Chemi	41/2/			kens Ave.			
			23a Part1 Enter the disease, or cor	nplications that caused	the death. Do not					Approximate
	Physician		Immediate Cause (Final				D.		-	Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	a. END STAI	consequence of):	MC OBSIL	DOIVE	TIMONAP	A MISE	RSG
	Examiner			Rici	17 lu	no M	ASS.			
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a	consequence of):		- Care			
	cutec nd ransi	Examiner	Cause (Disease or injury that initiated events	c	DNIGES	TIVE (	ARDIO	omyo	MTAG	4
Ö,	e exe	EX	resulting in death) Last	Due to (or as a	consequence of):			1		1
68760,	eath certificate be executed attending physicien and for use as the burial-transit	dicai	•	d						
_			IF FEMALE:	00- 11		- <u></u>				
P.O. Box	ath o	ian/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of	Fetal death	3 □Ectopic pregnand	у			ate of delivery onth Day Year
о О	The law requires that the death certif ate has been signed by the attending page 2 should be detached for use at	Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at 9□ Unknown	ime of death	5 Other (specify)				
	that the		Part II. Other significant conditions	contributing to death bu	t not resulting in th	e underlying cause gr	ven in Part I.	23e. Did t	obacco use con	tribute to the cause of death?
ds,	sign d be	d by	-		· ·	, , ,		10	Yes 2□No	3 Probably 4 □Unknown
Ö	w require been si	Completed						24a. Was	246	Wara autonov findings available
ž	has has	ш						autor	osy	Were autopsy findings available prior to completion of cause of death?
<u>_</u>	n: Th icate			T				1 ☐ Yes	5 No	1 ☐ Yes 2 No
₹	ilcfai certif recto	Be	25. Was case referred to medical examiner?	Hospital:		- Ott	205	ath (Check only o		
o	Phys r this ral di	<u>۲.</u>	1 Yes 2 No	28a. D te of Injur		tient 3 DOA	4   Nursing F	fome 5 Resident	dence 6 LJOth how injury occur	
Division of Vital Records,	ding h. After fune	tlon	Natural 5 ☐ Pending	(Month, Day	Year) Inju	ry Wo	rk? Yes 2 □ No			
S	Atten deat ctor: y the	fica	3 ☐ Suicide 6 ☐ Could not	be 290 Place of Inju	ry - At home, farm	street, factory, office		28f. Location (S	Street and Numl	ber or Rural Route Number,
	after Dire	Certification;	4  Homicide determine	building, etc	(Specify)	,		City or Tox	vn, State)	
	To the Hospital or Attending Physician: The I within 24 hours after death.  To the Funeral Director: After this certificate ha completely filled in by the funeral director, page		29a. Certifier 1 Certifying F	hysician: To the best of	f my knowledge, o	eath occurred at the t	me, date and place	and due to the	cause(s) and m	anner as stated.
	ns Ho n 24 l ne Fu	edicai	(Check only 2 Medical Exa	aminer: On the basis of and manner sta	examination and/o	r investigation, in my	opinion, death occu	irred at the time,	date and place,	and due to the cause(s)
	To the To the Comp	M	29b. Signature and title of certifier	) m -11-	m ~ '	29c. Licen	se number			ed (Month, Day, Year)
			> To Linger	mehta	111-0	D	41410		APRIL 1	1814, 2005.
	11/11		30. Name and address of person who	completed cause of de	ath (Item 23a) (Ty	pe, Print) Join	MOER P	MEH	1A	
	10.		H RESHHELDER H		NTER	BAHOAU			21133	)
	Sta		31. Date filed (Month, Day, Year)		r's Signature	all )	•			
	Regist	ar	APR 2 6 2005	Mark	AT POPE					

			State Registrar	te of Maryland / [		nt of H	ealth and	Mental Hyg	_	15 14150
,	Physici /Medio	al	1. Decedent's Name (First, Middle, Last)  Robert  4a. Facility Name (If not institution, give street a	villett	4b. Cit	y, Town, or	Location of Dea	2. Date of Dea Month	th Day	Year 2:30P M
	Examin Funeral	er	Herber Hespita 5. Social Security Number 6. Sex	2 Center 7. Age (In yrs. last bir	Bothday) If Unc	elt er 1 Year	MOY C	s. 8. Date of Birth	N	A  9. Birthplace (State or Foreign Country)
	Director		212 36 7912 1 X M 2 Usual Residence of Decedent	0.3	Yrs. Month	s Days	Hours Mir	Nov. 30	, 1941	Maryland
	ле Maryla 8e-f ehov	Director	Maryland N/A	10c. City, Town	timore					10d. Inside City Limits 1 ▼Yes 2 □ No
	with the		10e. Street and Number 2221 Sidney Avenue	2	10f. 2	ip Code 211	230	1	0g. Citizen of U.S	What Country?
036	within 72 hours after deeth with the Maryland liene. I then "natural", or Items 23a or 28e-f ehow The Medical Examiner must be notified at	by Funeral	11. Marital Status  1 Never Married 2 Married 1 Y	s Decedent Ever in U.S. ned Forces? ]Yes 2.∰No es, Give ar or Dates:		edent of Hi becify Cuba		Specify Yes or No- rto Rican, etc.)	14. Rad Bla	ce - American Indian, ck, White, etc. by: White
Maryland 21215-0036	d within giene. er then '	Completed	15. Decedent's Education (Specify only highest grade comp	llege (1-4or 5+)	Decedent's Us (Give kind of a life. DO NOT Self em	vork done d use retired	furing most of w	orking	Sports	usiness/Industry Store ement
yland	should be filed nd Mental Hygis marked other umatic event.	To Be C	17. Father's Name (First, Middle, Last) $Robert \ C$	. Willett				ame (First, Middle, elyn Colo		ne)
	nd 2 shu lith and 27 is m r treum		19a. Informant's Name/Relationship (Туре, Pri Carolyn Willett / Wi	ife 22	221 Sid	ney A	venue		e, Mary	land 21230
Baltimore,	Pages 1 ment of H ent: If Ite ury or ot		20a. Method of Disposition  1 □ Burial 2 □ Cremation 3 □ Remova  '4 □ Donation 5 □ Other (Specify)	II ROM State	f Disposition (A ry, crematory o ew Crem	atory	4/2	-,	Baltime	city or Town, State ore, Maryland
Ball	permit. Pag Department Importent: any Injury o		21. Signature of Funeral Service Licensee	merouch	4001	Ritch	nie High	way Balt	imore,	ervice, P.A. Maryland 21225
l	Prysician /Medical		23a. Party Enter the disease, or complications show, or heart failure. List only one cause immediate Cause (Final disease or condition resulting in death)	s that caused the death. Do not be on each line.  Or Corollary Cor	pha	gea	g, such as cardia	istul	est,	Approximate Interval Between Onset and Death
(09	ate be executed hysicien and hysicien and the burial-transit	ical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c.	Due to (or as a consequence						
68760,	tificate ig phys as the		d		-					
О. Вох	that the death certificat ed by the ettending phy detached for use as th	Physician/Med	in the past 12 months?	es, outcome of pregnancy ]Live birth 2∏Fetal death ]Pregnant at time of death ]Unknown	3 □Ectopic 5 □ Other (					ate of delivery onth Day Year
rds, P	The law requires that the site has been signed by the bage 2 should be detache	by	Part II. Other significant conditions contribution	ng to death but not resulting in	n the underlying	cause give	en in Part I.		_	tribute to the cause of death?
al Record		Completed						24a. Was a autops perform	ned?	Were autopsy findings available prior to completion of cause of death?  1 Yes 2 No
Vital	Physician: T this certificetral director, pa	o Be	25. Was case referred to medical examiner?  1 \( \subseteq \text{Yes} \) 2 \( \text{No} \) No	l: 1 Inpatient 2 ☐ ER/Ou	utpatient 3 🗆 I	Othe	ar.	eath <i>(Check only on</i> Home 5 - Reside		per (Spacify)
sion of	ath. r: After	<del> </del>	27. Manner of Death  Natural  Accident  28a  2 Pending investigation	. Date of Injury 28b.	Time of Injury	28c. Injury Work		28d. Describe ho		
Division	itel or Attend irs after death rel Director: , led in by the f	Certification;	4 L Homicide	. Place of Injury - At home, fa building, etc. (Specify)				City or Town	n, State)	ber or Rural Route Number,
	To the Hospitel or Atte within 24 hours after de To the Funerel Directo completely filled in by th	Aedical	(Check only 2 Medical Examiner: Or one)	To the best of my knowledge the basis of examination and manner stated.	nd/or investigation	on, in my op	oinion, death occ	curred at the time, d	ate and place,	and due to the cause(s)
	To To	M	29b. Signature and title of certifier of Internal M	edicine Iv	ntern ?	9c. License	500	1	A 1	19 200 S
	7		30. Name and address of person who complete	od cause of death (Item 23a)	(Type, Print)	10	imad.	er Mi	rol	
	Sta Registr		31. Date filed (Month, Day, Year)	32/Registrar's Signature	Sporte	7 7 0				

		1	For State Registrar	State of Marylar		artment of I		nd Mental H	lygiene2	005		151
	Physicia /Medic		1. Decedent's Name (First, Middle, Last) Fred Douglas Wy	che				2. Date of Month	Death Day	Year 2001	3. Time o	
	Examin	er	4a. Facility Name (If not institution, give s Union Memorial			4b. City, Town, Balti	lmore	Death		ounty of Death	h	
	Funeral Director			7. Age (In yrs.	last birthday) Yrs.	If Under 1 Year Months Days		Min. 8. Date of (Month,	Birth IV 191	9. Birth	hplace (State ountry) NC	or Foreign
	Maryland -f show		Usual Residence of Decedent  10a. State 10b. County N / A	10c. Ci	ity, Town or Lo	Baltin	ore				10d. Inside C	City Limits
	h with tha 3a or 28a st be notil	ai Direc	10e. Street and Number 4342 Parkside	Drive		10f. Zip Code	21206			n of What Co	-	
036	urs after deat at', or Itams 2 zandhar in U	by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Married  3 ☑ Widowed 4 □ Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	- I	Was Decedent of If Yes, specify Cul		in? (Specify Yes or Puerto Rican, etc.)		Race - Ame Black, White pecify:		k
Maryland 21215-0036	permit. Pages 1 and 2 should be filad within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or itams 23a or 28a-f show amy injury or other traumatic event. The Medical Exatrinal runt be notified at ance.	Completed	15. Decedent's Edu (Specify only highest grade	cation e <i>completed)</i> College (1-4or 5+)	(Give	dent's Usual Occu kind of work done DO NOT use retire O r e r	during most	of working		of Business/l	•	
land 2	uld be filad fental Hygi rked other lic event.	To Be Co	17. Father's Name (First, Middle, Last) Willis Wyche		. 1		18. Mother Mar	's Name (First, Mid Sy Buffa	dle, Maiden Su 10	ımame)		
, Mary	and 2 shoresalth and No. 27 la mai		19a. Informant's Name/Relationship (Ty Gloria Jenkins-				ide Dı	ror Rural Route Num cive Bal	to. MI			
Baltimore,	Pages 1: ment of He ant: If iten ury or oth		20a. Wethod of Disposition  1 Burial 2 Cremation 3 F  1 Donation 5 Other (Specify)	Removal from State Ki	ng Me	osition (Name of matory or other plans m. Park	(6)	pr Date 30 2005	Balt	tion - City or imore	, MD.	
Balt	permit. Depart Import any inj		21. Signature of Funeral Service Licens	Williams				liams Fu 1 Balto		Serv 2122		
	Pnysician /Medical	0	23a. Part1. Enter the disease, or compl shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	ne cause on each line.	nal 1	er the mode of dy	ing, such as o	cardiac or respirator	y arrest,		Approxima Interval Be Onset and 2 da	tween
	Examiner	ner	Sequentially list conditions,	b. Ongstw Due to for as a conse	Hea	et taile	ne				2 4	45
8760,	sate be executed bhysician and the burial-transit	dicai Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Hyperten Duend (or as a conse d. Prostate	guence of):	<u>Diate</u>	ter m	ellitus			10	yis y
Вох 6	death certific e attending p od for use as	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregr 1 Live birth 2 Fet 4 Pregnant at time of 9 Unknown	nancy al death 3[	□Ectopic pregnan	су		230	d. Date of deli Month		Year
rds, P.O.	requires that the di been signed by the hould be detached	by	Part II. Other significant conditions co	ntributing to death but not re	sulting in the u	indertying cause g	iven in Part I.	1	id tobacco use □ Yes 2 🔀 t		the cause of obably 4	
Vital Records,	The law ate has t page 2 s	Completed						24a. W al pr 1 🗆 Ye	erformed?	death?	topsy findings completion of	available cause of
of	ding Physician: Th h. After this certificate funeral director, pag	ation: To Be	27. Manner of Death  1 ⊠Natural 5 □ Pending	Hospital: 1 XInpatient 2[ 28a. Date of Injury (Month, Day Year)	ER/Outpatie	of 28c. Inj	ther: 4 Nur ury at ork?				cify)	
Division	or:	Certificat	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At building, etc. (Spec	home, farm, st hify)		]Yes 2∏N	28f. Location	n (Street and I Town, State)	Vumber or Ru	ıra <i>l Rout</i> e Nur	nber,
	Hospita 4 hours Funaral	ledical C		rsicien: To the best of my kr iner: On the basis of examin and manner stated.								s)
)		M	29b. Signature and title of certifier  Bangana K	amal a	M.D		1se number 124135	946		signed (Mont)		05
	7		30. Name and address of person who co	BANGORIA	201	East 4	niness	ity Park	way E	Baltin	ore Mi	0-21215
	Sta Regist		31. Date filed (Month, Day, Year)  APR 2 6 200	oza registrar s orgi	nature	and!		-	-		ď	

State of Maryland / Department of Health and Mental Hygierie For State Registrar Certificate of Death Reg. No. 2. Date of Death Decedent's Name (First, Middle, Last) 3. Time of Death April **Physician** 2005 21, Nyunt Yee 11:18 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Suburban Hospital Bethesda Montgomery 8. Date of Birth (Month, Day, Year) May 25, 1917 If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1 ☐ M 2 🖾 F Yrs. 212-04-4766 87 Director Burma Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City. Town or Location 10a. State 10b. County 10d. Inside City Limits of Heelth and Mental Hygiene. Item 27 is marked other than "naturel" or iteme 23s or 28s-f show other traumatic event, I've Medical Evandrar must be indiffed at 1 ☐ Yes 2 No Director Maryland Montgomery Bethesda 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8932 Bradmoor Drive 20817 United States Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Bace - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Asian 3 Widowed 4 □ Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Daw Shwe Meik 2 U Maung Sa 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tin Tin Nwe / Daughter 8932 Bradmoor Drive, Bethesda, Maryland 20817 April 23, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State \$ = 6 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State permit. Page Depertment of Important: If any injury or once. Montgomery Crematorium, Inc. Bethesda, Maryland 2005 ^ 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. ar Folkens M013567557 Wisconsin Avenue, Bethesda, Maryland 20814-3501 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Sepsis disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Middle Lobe Pneumonia Right Side Sequentially list conditions, if any, leading to immediate cause. Enter Ur Jerning Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner physician and s the burial-transit The law requires that the death certificate be executed Pulmonary Embolism Due to (or as a consequence of): Box 68760 Congestive Heart Failure use as IF FEMALE: . If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Year ţ Month Day 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown ρ signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Be Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an rmea? 2⊠ No certificate 1 ☐ Yes the Hospitel or Attending Physician: director 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 X Yes 2 ☐ No 1 ☐ Inpatient 2 X EP/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After 5 Pending investigation 1 X Natural Injury death. 1 ☐ Yes 2 ☐ No 2 Accident Director: 3 🖺 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funerel C 1 🖸 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ical 29a, Certifier (Check only one) 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0 D20279 April 22, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7710 Bradley Blvd., Bethesda, Maryland 20817 Kirti Vohra, M.D. 32. Registra Signature 31. Date filed (Month, Day, Year) State APR 2 6 2001 The River Registrar

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hydienes or

Alice Jewell Bradley  4a. Facility Name (If not institution, give street and number)  Southern Maryland Hospital Center  5. Social Security Number  408-09-3632  Usual Residence of Decedent  10a. State  April 11 2005 11:00 A  4b. City, Town, or Location of Death  Clinton  Clinton  Frince George's  Aug 1 1 1 2005 11:00 A  4c. County of Death  Prince George's  Aug 1 1 1 2005 Tennessee			Registrer  I. Decedent's Name (First, Middle, Last)	)		rtificate of D		2. Date of Deat	eg. No. th Day	Year	3. Time of Death
Southern Maryland Hospital Center    Southern Maryland   General	dical	I F		-				April 1	11 2	005	11:00 A
Social Security Number  4. See 1  4.	iner	4									
AUG		5						8. Date of Birth	Prin		
100. State   100. County   100. Dely from or Location   100. Per 2 g/k   100. Dely from or Location   100. Per 2 g/k   100. Delay from or Location   100. Per 2 g/k   100. Delay from or Location   100. Per 2 g/k   100. Delay from or Location   100. Per 2 g/k   100. Delay from or Location   100. Per 2 g/k   100. Delay from or Location   100. Per 2 g/k   100. Delay from or Location   100. Per 2 g/k   100. Delay from or Location   100. Per 2 g/k   100. Delay from or Location   100. Per 2 g/k   100. Delay from or Location   100. Per 2 g/k   100. Delay from or Location   100. Per 2 g/k   100. Delay from or Location   100. Per 2 g/k		2	408-09-3632 X	ТМ 2∏Е			Hours Min.	(Month, Day, AUG 1 1	Year) 1906		
11800 Earnshaw Court		-		10c. Cit	ty, Town or L	ocation				11	0d. Inside City Limits
USA	ctor	N	Maryland Prince G	eorge's B	randyw	ine					1 ☐ Yes 2 → No
11.860 Earnshaw Court	Dire	1	Oe. Street and Number			10f. Zip Code		1	0g. Citizen o	of What Coun	try?
Specify: White   Spec	ra										
Specify   Spec	n n	1		Armed Forces?	J.S. 13.	Was Decedent of Hisp If Yes, specify Cuban,	oanic Origin? (Sp Mexican, Puerto	ecify Yes or No- Rican, etc.)			
1. Mother's Name (First, Middle, Astain Summer)	Ş	2		If Yes, Give Year or Dates:		1 ☐ Yes 2 🖁 No	Specify:		Spec	city: Wh	ite
1. Mother's Name (First, Middle, Astain Summer)	sted	3			16a. Dece	edent's Usual Occupati	on ring most of work	cina	16b. Kind of	Business/Inc	lustry
Landon Huddleston  Tanine Hunter Huddleston  Tennie Hunter  Tennie Hu	noie				1		ing most of work	(III)			
Landon Huddleston   Tennie Hunter Fluddleston   School   Tennie Hunter Fluddleston   Tennie Fluddl					Hou		0.14.11				
19.0. Leafling Address (Street and Number or Plutal Route Number, City or Town, State, Zip Code)   19.0. Leafling Address (Street and Number or Plutal Route Number, City or Town, State, Zip Code)   20.1. Leafling State	œ	á				1				,	
Shirley B. Bogley (Daughter)  11800 Earnshaw Court Brandywine, MD 20613  20b. Reas of Disposition (Name of Order Dates)  20c. Deate of Disposition (Name of Order Dates)  21 Signatury of Fundance (Specify)  22 Signatury of Fundance (Specify)  23 Signatury of Fundance (Specify)  24 Disposition (Specify)  25 Signatury of Fundance (Specify)  26 Disposition (Specify)  27 Signatury of Fundance (Specify)  28 Disposition (Specify)  29 Disposition (Specify)  29 Disposition (Specify)  20 Disposition (Specify)  21 Signatury of Fundance (Specify)  22 Disposition (Specify)  23 Disposition (Specify)  24 Disposition (Specify)  25 Disposition (Specify)  26 Disposition (Specify)  27 Disposition (Specify)  28 Disposition (Specify)  29 Disposition (Specif	Ĕ			rpe. Print)	19b. Maili	ing Address (Street an					Codel
20. Place of Disposition (Name of Date   Dat											
Superstant of Furthal Service (Sepocity)   Superstant of Furthal Services   Approximate   Property   Superstant of Furthal Services   Moderate   Moderat		2	20a. Method of Disposition	20b. F	Place of Disp	osition (Name of					
21. Signature of Pythola Sarry Licenses   M00173   22. Name and Address of Facility Eberwein Funeral Services   A433 White Pls. IA. White Pls., MD 20695   A433 White Pls. IA. White Pls., IA. White Pls., MD 20695   A433 White Pls. Whi			1 ☐ Burtai 2 ☐ Cremation 3 ☐ YF  `4 ☐ Donation 5 ☐ Other (Specify)	temoval from State	-			5-05	Cross	ville,	TN
232   Militer Pls.   Machine Pls.   Militer Pls.   Militer Pls.   Month Pls.   Machine Pls.		1	21. Signature of Funeral Service Licens	M00173	2	2. Name and Address	of Facility Fibe				
Part III Other significant conditions contributing to death Dust for as a consequence of):			Mante	lun	4.	433 White	Pis. Ia.	White F	15.	MD 206	95
Sequentially list conditions   Cause (Disease or Injury that rindiand events resulting in death)   Last   Cause (Disease or Injury that rindiand events resulting in death)   Last   Cause (Disease or Injury that rindiand events resulting in death)   Last   Cause (Disease or Injury that rindiand events resulting in death)   Last   Cause (Disease or Injury that rindiand events resulting in death)   Last   Cause (Disease or Injury that rindiand events resulting in death)   Last   Cause (Disease or Injury that rindiand events resulting in death)   Last   Cause (Disease or Injury that rindiand events resulting in death)   Last   Cause (Disease or Injury that rindiand events resulting in death)   Last   Cause (Disease or Injury that rindiand events resulting in death)   Last   Cause (Disease or Injury Month Day Year   Last   Cause (Disease or Injury Alphaner or Death   Last   Cause (Disease or Injury Month Day Year   Last   Cause (Disease or Injury Alphaner or Death   Last   Cause (Disease or Injury Alphaner or Death (Check onty or Injury Size   Date of Injury Alphaner (Disease or Injury Month Day Year   Last   Cause (Disease or Injury Alphaner or Cause (Disease or Injury Alphaner or Rural Route Number (Check onty or Year)   Last   Cause (Disease or Injury Alphaner or Cause (Disease or Injury Cause or Cause (Disease or Cause (Dise		1		ications that caused the deat ne cause on each line.	th. Do not en	iter the mode of dying,	such as cardiac	or respiratory arre	est.		Approximate Interval Between
Sequentially list conditions.    Sequentially list conditions.	ı		Imprediate Cause (Final disease or condition	CARCINON	MA (	PANCRE	AS				
Part		Т	resulting in dealtry		quence or):						
The stating in death   Last   Due to (or as a consequence of):   Jue to (or as a consequence of consequence of death):   Jue to (or as a consequence of consequence of death):   Jue to (or as a consequence of consequence of death):   Jue to (or as a consequence of consequenc	l.					A				0	11.102
IFFEMALE:   23b. Was decedent pregnant in the past 12 months?   1	i di	5 1	Sequentially list conditions.	Due to (or as a consec	TIVE	JAUNA	CE			15	*pitch o
23c. If yes, outcome of pregnancy   1	mine		Sequentially list conditions, I any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a conseq	TIVE	JAUNDI	CE			2	illi osat
FFEMALE:   23b. Was decedent pregnant   1	Examine	1	that initiated events	Due to (or as a consec	junnou (af)r	JAUNDI	CE			2	illiosat
HYPER TENSIVE HEART DISERSE  1   Yes 2   No 3   Probably 4   Unknow a uptopsy performed? 1   Yes 2   No 3   Probably 4   Unknow a uptopsy performed? 1   Yes 2   No 3   Probably 4   Unknow a uptopsy performed? 1   Yes 2   No 3   Probably 4   Unknow a uptopsy performed? 1   Yes 2   No 3   Probably 4   Unknow a uptopsy performed? 1   Yes 2   No 3   Probably 4   Unknow a uptopsy performed? 1   Yes 2   No 3   Probably 4   Unknow a uptopsy performed? 1   Yes 2   No 3   Probably 4   Unknow a uptopsy performed? 1   Yes 2   No 3   Probably 4   Unknow a uptopsy performed? 1   Yes 2   No 3   Probably 4   Unknow a uptopsy performed? 1   Yes 2   No 3   Probably 4   Unknow a uptopsy performed? 1   Yes 2   No 3   Probably 4   Unknow a uptopsy performed? 1   Yes 2   No 3   Probably 4   Unknow a uptopsy performed? 1   Yes 2   No 3   Probably 4   Unknow a uptopsy performed? 1   Yes 2   No 3   Probably 4   Unknow a uptopsy performed? 1   Yes 2   No 1   Yes 2   No 1   Yes 2   No 2	lical Examine	1	that initiated events	Due to (or as a consec	junnou (af)r	JANUAT	CE.			2	illiosat
Sample of the significant contributing to death out not resulting in the underlying cause given in Part 1.   238. Did tobacco use contribute to the cause of death?	ledicai		resulting in death) Last	Due to (or as a consect.  Due to (or as a consect.	quence of):	JAUNAI	CE.			4	illiosat Il Am
### Part II. Other significant contributing to death but not resulting in the underlying cause given in Part I.  ### 1	ledicai		resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	Due to (or as a consect of pregnation of pre	quence of): ancy al death 3[	□Ectopic pregnancy	CE.		1	Date of deliver	ypricedo
PAROXYSMAC ATRIFIC FIBRILLATION  24a. Was an autopsy performed? 1 yes 2 No 3 Probably 4 Unknown autopsy findings available prior to completion of cause of death? 1 yes 2 No 3 Probably 4 Unknown autopsy findings available prior to completion of cause of death? 1 yes 2 No 1 No 1 Yes 2 No 1 No 1 No North N	ledicai		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 (52No	Due to (or as a consect of Due to (or as a conse	quence of): ancy al death 3[	□Ectopic pregnancy	CE.		1	Date of deliver	ypindo
25. Was case referred to medical examiner?  1	Physician/Medical		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 PNo 9 Unknown	Due to (or as a consect of pregnance).	quence of): ancy al death 3[ Jeath 5[	□Ectopic pregnancy □ Other (specify)		23e. Did tob	, ,	Date of deliver	y Year
25. Was case referred to medical examiner?	by Physician/Medical		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 PNo 9 Unknown	Due to (or as a consect of pregnance).	ancy al death 3 [ death 5 [	□Ectopic pregnancy □ Other (specify) underlying cause given			pacco use co	Date of deliver	y Year e cause of death?
25. Was case referred to medical examiner?  1	by Physician/Medicai		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 (SNo 9 Unknown)	Due to (or as a consect of the conse	ancy al death 3[ death 5[ sulting in the control of	□Ectopic pregnancy □ Other (specify) underlying cause given		1 ☐ Ye 24a. Was ar	pacco use cons 2 No	Date of deliver	Ty Day Year  e cause of death?  ably 4 □Unknown  psy findings available
1   Yes   2   No	ompieted by Physician/Medical		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 (SNo 9 Unknown)	Due to (or as a consect of the conse	ancy al death 3[ death 5[ sulting in the control of	□Ectopic pregnancy □ Other (specify) underlying cause given		1 Tye	pacco use consist 2 KNo	Date of deliver	Day Year  e cause of death?  ably 4 Unknown  by findings available appletion of cause of
29a. Certifier (Check only one)  29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)	Completed by Physician/Medical		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2  No 9 Unknown  Part II. Other significant conditions con HYPER TENSIVE PAROXYS MAC	Due to (or as a consect.)  Pegnant at time of consect.  Due to (or as a consect.)  Pegnant at time of consect.  Due to (or as a consect.)  Pegnant at time of consect.  Due to (or as a consect.)  Due to (or as a consect.)  Pegnant at time of consect.  Due to (or as a consect.)  Due to (or as	ancy al death 3[ death 5[ sulting in the control of	□Ectopic pregnancy □ Other (specify) underlying cause given	in Part I.	1 Yes  24a. Was ar autops perform 1 Yes 2	pacco use co ns 2 No nad? 24t	Date of deliver Month  Ontribute to the 3 Probab. Were autoprior to condeath?  1 Yes	Py Day Year  e cause of death?  ably 4 Unknown  by findings available apletion of cause of 2 No
29a. Certifier (Check only one)  29b. Signature and title of certifier  29c. License number  29c. License number  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)	To Be Completed by Physician/Medical		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2  No 9  Unknown Part II. Other significant conditions con HYPER TENSIVE PAROXYSMAC	Due to for as a consect.  Petalogous for as a consect.  Due to for as	ancy al death 3 (death 5 (	□Ectopic pregnancy □ Other (specify) □ underlying cause given □ ← ← ← ← ← ← ← ← ← ← ← ← ← ← ← ← ← ← ←	in Part I. 26. Place of Deat 4 □ Nursing Ho	1 Yes  24a. Was ar autops perform 1 Yes 2	pacco use co ns 2 No nad? 24t	Date of deliver Month  Ontribute to the 3 Probab. Were autoprior to condeath?  1 Yes	Day Year  e cause of death?  ably 4 Unknown  by findings available  pletion of cause of  2 No
29a. Certifier (Check only one)  29b. Signature and title of certifier  29c. License number  29c. License number  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)	To Be Completed by Physician/Medical		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to for as a consect.  Petalogous for as a consect.  Due to for as	ancy al death 3[ death 5[ BRILL  BRIL	DEctopic pregnancy Other (specify)  underlying cause given CE  ATION  ont 3 DOA Other of 28c. Injury a Work?	in Part I. 26. Place of Deat 4 □ Nursing Ho	24a. Was ar autops perform 1 Yes 2 th (Check only one 5 Reside	pacco use constant 2 Management	Date of delivered Month  Dontribute to the second prior to condeath?  1 Yes	Day Year  e cause of death?  ably 4 Unknown  by findings available  pletion of cause of  2 No
29a. Certifier (Check only one)  29b. Signature and title of certifier  29c. License number  29c. License number  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)	To Be Completed by Physician/Medical		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or as a consect.)  Feature 1  Due to (or as a consect.)  For a consect.  Due to (or as a consect.)  For a consect.  Due to (or as a consect.)  For a consect.  Due to (or as a consect.)  For a consect.  Due to (or as a consect.)  For a consect.  Due to (or as a consect.)  For a consect.  Due to (or as a consect.)  Due to (or as a consec	ancy al death 3[ death 5[ BRILL  BRIL	□Ectopic pregnancy □ Other (specify) □ underlying cause given □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □	in Part I. 26. Place of Deat 4 □ Nursing Ho	24a. Was ar autops: perform 1 Yes 2 2th (Check only one 5 Reside 28d. Describe ho	pacco use consist 2 MNo 24by 24by 24by 24by 25by 25by 25by 25by 25by 25by 25by 25	Date of deliver Month  Ontribute to th  3 Proba  b. Were autoperior to condeath? 1 Yes  Other (Specify)	Py Day Year  e cause of death?  ably 4 Unknown  by findings available appletion of cause of 2 No
29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)  4/12/05	To Be Completed by Physician/Medical		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or as a consect.)  Pega.  Pega.  Peta.  P	ancy al death 3 (death 5 (	□Ectopic pregnancy □ Other (specify) □ underlying cause given □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □	in Part I. 26. Place of Deat 4 □ Nursing Ho	24a. Was ar autops perform 1 Yes 2 th (Check only one 5 Reside 28d. Describe ho	pacco use constant and selection of the	Date of deliver Month  Ontribute to th  3 Proba  b. Were autoperior to condeath? 1 Yes  Other (Specify)	Day Year  e cause of death?  ably 4 Unknown  by findings available appletion of cause of 2 No
) Salah Jumani H.D > 35295 4/12/05	Certification: To Be Completed by Physician/Medical		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or as a consect of the conse	ancy al death 3 (death 5 (deat	DEctopic pregnancy Other (specify)  underlying cause given  ATION  ont 3 DOA Other.  28c. Injury a Work? M 1 Ye  freet, factory, office	in Part I.  26. Place of Deat  4 \( \text{Nursing Ho} \)  the 2 \( \text{No} \)  date and place	24a. Was ar autops: perform 1 Yes 2 th (Check only one 5 Reside 28d. Describe ho 28f. Location (Str. City or Town	pacco use constant and selection of the	Date of deliver Month  Ontribute to th  3 Proba  b. Were autop prior to condeath? 1 Yes  Other (Specify curred	Py Day Year  e cause of death?  ably 4 Unknown  by findings available appletion of cause of 2 No  Route Number,
	edical Certification: To Be Completed by Physician/Medical		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or as a consect of the conse	ancy al death 3 (death 5 (deat	DEctopic pregnancy Other (specify)  underlying cause given  Contact 3 DOA Other  28c. Injury a Work? M 1 Ye treet, factory, office th occurred at the time, nvestigation, in my opin	in Part I.  26. Place of Deat  4 \( \text{Nursing Ho}\)  It  is 2 \( \text{No}\)  In date and place, alon, death occur	24a. Was ar autops: perform 1 Yes 2 th (Check only one 5 Reside 28d. Describe ho 28f. Location (Str. City or Town and due to the cared at the time, da	pacco use constant and place of the constant	Date of deliver Month  Description to condeath?  Description of the condeath o	Poute Number,  ated.  the cause(s)
	edical Certification: To Be Completed by Physician/Medical		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or as a consect of Due to (or as a conse	ancy al death 3 (death 5 (deat	DEctopic pregnancy Other (specify)  underlying cause given  C  ATLON  of 28c. Injury a Work? M 1 Yesteet, factory, office th occurred at the time, nvestigation, in my opin	in Part 1.  26. Place of Deat  4 \( \text{Nursing Ho}\)  It  is 2 \( \text{No}\)  Induction, death occur  number	24a. Was ar autops: perform 1 Yes 2 th (Check only one 5 Reside 28d. Describe ho 28f. Location (Str. City or Town and due to the cared at the time, da	pacco use constant and place and pla	Date of deliver Month  Date of deliver Month  Deliver	Poute Number,  and the cause(s)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For Stata Ragistrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year 11:18 A M 12 Hodel 2005 Jenese 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death MARYLAND linton 9. Birthplace State or Foreign Huspits Douthern If Under 1 Year If Under 24 Hrs. 8. Date of Birth Month, Days Hours Min. March 7 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Months Year 1 ☐ M 2 🖼 🕈 Pennsylvania Yrs. 283-36-4701 66 Usual Residence of Decedent 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits 1 Tes 2 No Maldor Maizyland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3101 USA 20602 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Hace - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No 3 ☐ Widowed 4 ☑ Divorced Specify: Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Clerk 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Lowe Auc 19a. Informant's N e/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Classic Tinder Place MI) MISCILA 1) Aughter 20b. Place of Disposition (Nable of 14850 20c. Lo tion - City or Town, State 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Date cemetery, crematory or other place) \* 4 ☐ Donation 5 ☐ Other (Specify) 4-18-05 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Home PA 20637 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cluse on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) PULMONARY Due to (or as a consequence of): METASTAT Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Year 4☐Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown

Physician /Medical **Examiner** 

permit. Pages 1 and 2:
Department of Health at Importent: If item 27 is eny injury or other treu once.

**Physician** 

/Medical

Examiner

Directo

by Funeral

Completed

Be

2

**Funeral** 

Director

Pages 1 and 2 should be tiled within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

ont: If item 27 is marked other then "naturel", or items 23a or 28a-f show

Hygiene.

Baltimore, Maryland 21215-0036

77 is marked other then "naturel", or items 23a or 28a-f show treumatic event, the Modical Exertiner must be notilised at

Examine anding physician and use as the burial-transit Physician/Medical attending p signed to þ icate has been sign, page 2 should b Be Completed director 2 Certification:

the à

certificate

this

After

Director:

within 24 hours a To the Funerel C

cal

death.

To the Hospitel or Attending Physicien: The law requires that the death certificate be executed

Box 68760.

P.O. |

Division of Vital Records.

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No

5 Pending

investigation

6 Could not be determined

25. Was case referred to medical

1 ☐ Yes 2 🛣 No

examiner'

27. Manner of Death

1 Natural 2 Accident

3 Suicide

4 Homicide

24a. Was an autopsy 1 Yes 2 No

24b. Were autopsy findings available prior to completion of cause of death? 2 No 1 TYes

26. Place of Death Check on one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Unpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Injury 1 ☐ Yes 2 ☐ No

D46478

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Location (Street and Number or Rural Route Number, City or Town, State)

4-12-05

29a. Certifier 1 Contifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Clinton mp Patelly Surratts Rel. 750 31. Date filed (Month, Day, Year)

State Registrar APR 1 4 2005

		1 - For Stata Registrar	State	of Maryla	ind / Depa <i>Cei</i>	artment rtificate			ınd Me	_	giene	CUU	14155
Physici /Medi		Decedent's Name (First, Middle Mary Jo Brailer	, Last)						2	. Date of De Month	ath rch Ba	Y, 2005 <sup>ear</sup>	3. Time of Death 11:35A M
Examir		4a. Facility Name (If not institution 10904 Kreigbaum F				4b. City, 1		Location of			Al Al	County of Dea legany	th
Funeral Director		5. Social Security Number 215-20-5766	6. Sex 1 ☐ M 2 ☐ F	7. Age (In yr 78	s. last birthday) Yrs.	If Under Months	1 Year Days	If Under 2 Hours	Min. 8	Date of Bir Month, Da O-May-	th V Xaar) 1920	9. Bir Mai	thplace (State or Foreigr Syntry) y Idi11d
Maryland f show	ior	Usual Residence of Decedent           10a. State         10b. County           Maryland         Alle	gany		City, Town or Lo								10d. Inside City Limits 1X Yes 2 □ No
h with the	al Director	10e. Street and Number 10904 Apt. 3		Road		10f. Zip					10g. Cit U.S.	izen of What Co	ountry?
urs after death al', or Items 2	by Funeral	11. Marital Status  1 Never Married 2 Marr  3 Widowed 4 Divorced	Armed F	ive No		Was Decedif Yes, special		spanic Orig n, Mexican, Specify:	gin? (Speci , Puerto Ri	fy Yes or No can, etc.)	)-	14. Race - Ame Black, Whit	te, etc.
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other treumatic event, I've Medicul Exatiting minestice invitibed at once.	Completed	15. Deceden (Specify only higher Elementary/Secondary (0-12)	t grade completed	) (1-4or 5+)	16a. Dece (Give life. homen	dent's Usual kind of word DO NOT usi 1aker	l Occupa k done d e retired	ition luring most )	of working	,		ind of Business emaker	
ould be filed Mentat Hyg arked other	To Be C	17. Father's Name (First, Middle, Joseph Malloy						Marga	ret Mu	_			
and 2 sh ealth and m 27 Is m		19a. Informant's Name/Relations William Brailer	hip (Type, Print) SON	1	4			ind Numbei	Da raic	·		or Town, State, A Aaryland	21502
rmit. Pages 1 partment of H portent: If Ite y injury or otl		20a. Method of Disposition  Burial 2 Cremation  4 Donation 5 Other (S	oecify)	Ctata	Place of Dispo cemetery, crei	natory or other s Cemet	her place ery		_			t Savage N	
permit Depar Impor any in		21. Signature of Funeral Service	Ruce	d	Du	2. Name and ISt Fun	eral ]	s of Facility Home,	57 Fro	st Ave.,	Fros	tburg MI	D 21532
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and properties of the Funeral Director. After this certificate has been signed by the attending physician and properties of the Funeral director, page 2 should be detached for use as the burial-transit	dicai Examiner	23a. Pin. Enter the disease, or ock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. hy Due to b. at Oue to	perter (or as a cons	nsion equence of): fibril equarea of): thriti	atior							Interval Between Onset and Death
the death certific y the attending p sched for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	1 Live	utcome of preg birth 2 Fe nant at time of nown	etal death 3	Ectopic pre Other (spe						23d. Date of del Month	livery Day Year
w requires that the de been signed by the a should be detached f	by	Part II. Other significant condition alzheimer			esulting in the u	nderlying ca	use give	n in Part I.		23e. Did t	_	<b>✓</b>	o the cause of death?
sician: The law requirection: The Jaw requirection page 2 shoul	Completed				-					1 Yes	psy prmed? 2/2 No	prior to death?	utopsy findings available completion of cause of
To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	ation; To Be	25. Was case referred to medical examiner?  1 Yes 2 No  27. Manner of Death Natural 5 Pendin investig	Hospital: 1 28a. Date (Moderation	Inpatient 2 of Injury oth, Day Year)	ER/Outpatier 28b. Time of Injury		Bc. Injury Work	r: 4 □ Nur	rsing Home	Check only of Residue. Describe h	dence	6	cify)
ital or Atternation after de ral Directo	Certification;	3 Suicide 6 Could determ	ined 288. Plac build		home, farm, str cify)					City or Tov	wn, State	)	ural Route Number,
hs Hosp in 24 hou he Fune pletely fil	Medical	one) 2 Medical		e best of my k basis of exami nner stated.	nowledge, death nation and/or in	n occurred a vestigation,	it the tim in my op	e, date and inion, deatl	d place, and h occurred	d due to the at the time,	cause(s) date and	and manner as d place, and due	s stated. to the cause(s)
To t with To t	×	29b. Signature and title of certifie						9121				te signed (Mont. $4/01/2$	
nds		30. Name and add ss of person T. Malik			em 23a) (Type, 1t Ave		ite	204	Cu	mber1	and	, MD	21502
Sta Regist	ate rar	31. Date filed (Month, Day, Year) APR 0 4		Registrar's Sig	nature M. A.	cati s	4						

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1 - State Registrar	State of Maryl		tificate of De			Z 0 0 5	4   56
	Physicia	an	Decedent's Name (First, Middle, Last		D -		1	2. Date of Death Month	Day Year	3. Time of Death
	/Medic	al	Luretta 4a. Facility Name (If not institution, give	Mae	Re	eman 4b. City, Town, or Lo	cation of Death	04	4c. County of Deat	10:29AM
	Examin	er		rt Hospi	tal	Cumbe	4 4	(	Alleg	
	Funeral		Social Security Number     6. Se	x 7. Age (In)	yrs. last birthday)	If Under 1 Year If	Under 24 Hrs. Hours Min.	B. Date of Birth (Month, Day, Y		hplace (State or Foreign untry)
	Director		213-22-3729 Usual Residence of Decedent	□M 2X)F 82	Yrs.	34,6	100/0	01/12/192		nsylvania
	/land		10a. State 10b. County	10c.	. City, Town or Lo	cation				10d. Inside City Limits
	a-f sh	to	MD Allega	ny	F1	intstone				1 ☐ Yes 2 🛣 No
	ith the	Oire	10e. Street and Number			10f. Zip Code		100	J. Citizen of What Co	untry?
	filed within 72 hours after death with the Maryland Hygiene, ther than "natural", or Iteme 23a or 28a-f show ther than "natural", or Iteme from the notified at	by Funeral Director		ntstone Creek l	-	21530			USA	
	ther de	Fune	11. Marital Status 1 ☐ Never Married 2 ☑ Married	12. Was Decedent Ever in Armed Forces?  1 ☐ Yes 2 ☑ No	in U.S.   13. V	Vas Decedent of Hispa Yes, specify Cuban, N	anic Origin? (Spec Mexican, Puerto R	ify Yes or No- ican, etc.)	14. Race - Ame Black, White	
21215-0036	ral', or	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	1	Yes 2 No S	Specify:		Specify:	White
5-0	72 hc	Completed	15. Decedent's Edu (Specify only highest grad	cation e completed)	16a. Deced	ent's Usual Occupation kind of work done during OO NOT use retired)	n ng most of working	16	b. Kind of Business/	Industry
121	within ane. than '	mp	Elementary/Secondary (0-12)	College (1-4ar 5+)	life. L		•		**	
<b>d</b> 2	fited with! Hygiene, other than		12 17. Father's Name (First, Middle, Last)			Homemaker 18	. Mother's Name (	First, Middle, Ma	Homem	aker
Maryland	2 should be fi and Mental H le marked ot reumatic ever	To Be	John Wi	llis	Hendrick	kson	Helen	Re	osannah R	ice
lary	2 sho and h le ma		19a. Informant's Name/Relationship (7)			g Address (Street and				
	1 and 2 Health tem 27		Calvin E. Beeman / hu		-	W. Flintston			· .	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or iteme 23a or 28a-f show any injury or other treumatic event, the Medical Evaninat must be notified at 906a.		20a. Method of Disposition 1   ☐ Burial 2 ☐ Cremation 3 ☐ F	Removal from State		natory or other place)	Da		c. Location - City or	Town, State
鼍	artmel ortent Injury		* 4 □ Donation 5 □ Other (Specify)  21. Signature of Auneral Service Licens		I.0.0.F.	Cemetery  Name and Address o	04/04/2		lintstone, l	
B	Depar Impo any Ir		+ Kelt C.	200 .		404 Decatur				e, F.A.
	The total		23a. Part1. Enter the disease, or composhock, or heart failure. List only o	ications that caused the d						Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	A CUTE IT						Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a con-	sequence of):					- Italy
	750	ē	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a con:	sequence of):				0.53	
	cuted nd ransit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c						
50,	oe exe		resulting in death) Last	Due to (or as a con-	sequence of):					
68760,	rificate be executed no physicien and as the burial-transit	Medical		d						
Box (		n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pre					23d. Date of deli	verv
	0 0 0	Physician/N	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live birth 2 F 4 Pregnant at time of 9 Unknown		Ectopic pregnancy Other (specify)			Month	Day Year
P.0	that the de ted by the a detached f	Phys	9 Unknown							
ds,	signed be det	by	Part II. Other significant conditions co		resulting in the un	derlying cause given in	n Part I.		cco use contribute to	the cause of death?
Records,	w requir been s should	letec	CORDINARY		D SM E			-		
Re	has has	Completed	COLDINAMO	141016409 18	13/10/			24a. Was an autopsy performe	d? prior to death?	topsy findings available completion of cause of
Vital	icien: Th certificate rector, pag	0	25. Was case referred to medical			26	3. Place of Death (	1 Yes 2 b	No 1 ☐ Yes	2 No
of V	Physicien: rthis certificaral director, I	To B	1 162 5 140		2 ER/Outpatien	3 DOA Other:	4 - Nursing Home	9 5 ☐ Residend	ce 6 □Other (Spec	eify)
	ding P. h. After 1 funera	lon:	27. Manner of Death  1 Matural 5 ☐ Pending	28a. Date of Injury (Month, Day Year	r) 28b. Time of Injury	28c. Injury at Work?		d. Describe how	injury occurred	
Division	eat or:	ficat	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - A	At home, farm, stre		2 No	f. Location (Stree	et and Number or Ru	ral Route Number
ă	s after	Certification:	4  Homicide	28e. Place of Injury - A building, etc. (Sp	ecify)	,,		City or Town, S	State)	
	To the Hospitel or Ati within 24 hours after d To the Funerel Direct completely filled in by		29a. Certifier 1 Certifying Phy (Check only 2 Medical Exami	sician: To the best of my ner: On the basis of exam	knowledge, death	occurred at the time, o	date and place, an	d due to the caus	se(s) and manner as	stated.
	thin 24 thin 24 the F	Medical	29b. Signature and title of certifier	and manner stated.		29c. License nu				
	5 ± 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		Soc. Orginature and title of certifier	) 00	7	29C. License nu			Date signed (Month	
,	5		30. N e and address of e on who co	ompleted cause of death (	Item 23a) (Type, I				PRIL I	
	かん		Dr. Gregg C. Dor	budson 9k	a Seto	n Drive	Lumb	triano	I. MD a	21502
E	Sta Registr		31. Date filed (Month, Day, Year) APR 0 4 2	32. Registrar's Si	ignature	rest				

			1 - For State Registrar	State of Ma	ryland		artment of F				giene	UU.	5	14157
	Dharis		1. Decedent's Name (First, Middle, Last)						2	. Date of De	ath		Vaar	3. Time of Death
	Physici /Medio		Wayne	Α		Вс	ggess		Aı	pril 8	3, 20	005_	Year	10:10 A M
	Examir	er	4a. Facility Name (If not institution, give				4b. City, Town, o		of Death			County		
	4	Ш	Southern Maryland		(1	A 6:	Clint If Under 1 Year	ON If Under:	04 Hrs. To					orge's
	Funeral Director		5. Social Security Number 6. Security 15 15 216-82-0177	2 F 7. Age	(In yrs. lasi	Yrs.	Months Days	Hours	Min.	Date of Bir (Month, Da 1g • 26	y, Year)	957	9. Birthi Cou Mai	place (State or Foreign intry) ryland
	and		Usual Residence of Decedent  10a. State 10b. County		10c. City, 7	Fown or Lo	cation							10d. Inside City Limits
	Maryl sho	ō	Maryland Prince Ge		,		Marlboro							1 ☐ Yes Ž(ŽNo
	r 28a	irec	10e. Street and Number	.0160 0		ppci	10f. Zip Code				10g. Citi	izen of W	hat Cou	ntry?
	th wit	ai D	12805 Shuttle Plac	e			20	772				USA	L	
36	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or Items 23a or 28a-1 show aumatic event, the Medical Examinat must be notified at	by Funeral Director	11. Marital Status  1   Never Married 2 Married  3   Widowed 4   Divorced	12. Was Decedent E- Armed Forces? 1 ☐ Yes 2 ☑ Mo If Yes, Give Year or Dates:			Was Decedent of H f Yes, specify Cuba I ☐ Yes 2☑ No	ispanic Ori an, Mexican Specify:		y Yes or No can, etc.)	-		, White,	
8	2 hour	edt	15. Decedent's Edu		1	16a, Deced	lent's Usual Occup	ation			16b Ki	nd of Bus	siness/in	ndustry
215	hin 7%	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+	-)		kind of work done of OO NOT use retired	*						oustry
2	ed with	Com	Special Ed.  17. Father's Name (First, Middle, Last)	0010g0 (1 401 51		She1	tered Em	ploym	ent			Me	1woo	od
Maryland 21215-0036	l be filk ntal H) ed oth	Be	17. Father's Name (First, Middle, Last) Harold Boggess							First, Middle, Cerson		Sumame	9)	
<u> </u>	should td Me mark matic	ပ	19a. Informant's Name/Relationship (Ty	pe Print)		19h Mailin	g Address (Street					r Town S	State Zie	Code)
<i>®</i>	nd 2 salth ar 27 is r trau		Harold Boggess /											ie, FL 3495
Baltimore,	permit. Pages i and 2 should be Department of Health and Menta Important: If Item 27 is marked any injury or other traumatic ex once.		20a. Method of Disposition  1X Burial 2 ☐ Cremation 3 ☐ R  4 ☐ Donation	emoval from State	cem	etery, cren	sition (Name of natory or other place ort Cemete		Date 4/12/2					own, State Virginia
Balti	permit. Departm Importa any inju		21. Signature uneral Service License	elas h		22	. Name and Addres	ss of Facilit	eorge	P. Ka	las	Fune	ral	Home PA
	Physician		23a. Part1 Enter the disease, or compliance, or heart failure. List only or Immediate Cause (Final disease or condition	ne cause on each line	he death. I							1, M	<u>ar</u> vJ	Approximate Interval Between Onset and Death days
E	/Medical Examiner		resulting in death)	Due to (or as a										
		e.	Sequentially list conditions, if any, leading to immediate	Due to (or as a	LMONTA consequen									days
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events		ER FAT									years
o,	icate be executed physician and s the burial-transit	Еха	resulting in death) Last	Due to (or as a										Jears
8760	cate b	dicai												
O. Box 6	The law requires that the death certificate be executed tte has been signed by the attending physician and oage 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown	3c. If yes, outcome o 1 □ Live birth 2 4 □ Pregnant at ti 9 □ Unknown	☐ Fetal de	ath 3	Ectopic pregnancy Other (specify)				2	23d. Date Mont		ery Day Year
٠.	that the ed by detac	Ph	Part II. Other significant conditions con	ntributing to death but	not resultin	ng in the un	deriving cause give	en in Part I.		23e. Did to	bacco u	se contrit	oute lo Il	ne cause of death?
Records,	w requires that been signed b should be deta	ted by									∕es x2.5x			pably 4 Unknown
		Completed				-				24a. Was autop perfo 1 Yes	rmed?	pri de	ior to cor eath?	ppsy findings available mpletion of cause of 2 No
Vital	sician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	lospital:			Othe			check only o				
Division of	Phys this aldi	tion; To	1  Yes 2 XXo  27. Manner of Death 1 XXatural 5  Pending 2  Accident investigation	1 kmpatient 28a. Date of Injury (Month, Day	28	Outpatient  Time of Injury	28c. Injury Work	at	28d	5 🗌 Resid				/)
DIVIS	To the Hospital or Attending F Within 24 hours efter death. To the Funeral Director; After completely filled in by the funer	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injur- building, etc.	y - At home (Specify)	, farm, stre	eet, factory, office		28f.	Location (S City or Tox	Street and m, State)	1 Number	r or Rura	il Route Number,
	ne Hospitt n 24 hours ne Funera sletely fille	Medical C	29a. Certifier (Check only one) 1 Certifying Phys 2 Medical Examin	sician: To the best of ner: On the basis of e and manner state	examination	dge, death and/or inv	occurred at the timestigation, in my or	ne, date and pinion, deat	d place, and th occurred a	due to the dat the time,	cause(s)	and mani place, ar	ner as st	ated. the cause(s)
	Top	ž	29b. Signature and title of certifier		/		29c. License	number						Day, Year)
	(2)		I Than	M.D. P	6)			7937			04	/08/	2005	
_	ge.			PhD. Son	uther	n Mar	yland Hos	spital	1 , C1	inton	, Ma	ryla:	nd	
	Sta Registr	_	APR 1 2 2005	32. Registrar	's Signature	"Les								

			1 - State Registrar		eartment of Health and l ertificate of Death		2005 14158
	Physicia	an	Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day Year 3. Time of Death
	/Medic	al	James Will		4b. City, Town, or Location of Deatl	<del></del>	Day 18 2005 1555 P M  4c. County of Death
	Examin	er	4a. Facility Name (If not institution, give street and Laurelwood Care Center		Elkton		Cecil
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birthday	If Under 1 Year If Under 24 Hrs.	8. Date of Birth	0. Birthologo /State or Foreign
	Director		232-14-7484 ¹™ ²□F	85 Yrs.	Months Days Hours Min.	FEB 24,	1920 Virginia
	and	1	Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or L	ocation		10d. Inside City Limits
	Maryl -f sho	ţŏ	Maryland Cecil	E1kton			1 ☐ Yes 2 💢 No
	th the	Directo	10e. Street and Number		10f. Zip Code	10g	g. Citizen of What Country?
	23a cust b	raic	107 Chestnut Hill Lar		21921		United States
	er der Itama	Funerai	11. Marital Status  1 Never Married  2 Married  1 XYe	ecedent Ever in U.S. 13. Forces? World	. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer	pecify Yes or No- to Rican, etc.)	14. Race - American Indian, Black, White, etc.
036	filed within 72 hours after deeth with the Maryland Hygiene. sther than "naturel", or Itams 23a or 28a-f show sht, the Madical Examiner must be natified at	by	If YAS.	Give War II	1 ☐ Yes 2 📉 No Specify:		Specify: White
21215-0036	72 ho	Completed	15. Decedent's Education (Specify only highest grade complete	ad) (Give	edent's Usual Occupation e kind of work done during most of wo	rking 16	Sb. Kind of Business/Industry
121	within ne. han *	mpi	Elementary/Secondary (0-12) College	e (1-4or 5+)	uck Driver		Trucking
0 0	filed v Hygie other 1	ဝ	9 17. Father's Name (First, Middle, Last)			me (First, Middle, Ma	
an	Mental Mental rked c	To Be	Elijah J. Bowman		Vida 1	Belle Cart	er
Maryland	and N is ma		19a. Informant's Name/Relationship (Type, Print)		ling Address (Street and Number or Ru		
, Z	and sealth m 27		Ruth B. Bowman/Wife	P.O.	Box 331, Elkton,		21922-0331 Oc. Location - City or Town, State
101	nt of h		1 X Burial 2 ☐ Cremation 3 ☐ Removal fro	om State North Ea	ematory of other place) st Apri	11 21,	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan Department of Health and Mental Hygiene. Importent: If Item 27 is marked other than "naturel, or Itams 23a or 28a-f show any Injury or other treumatic event, the Mudical Examiner must be notified at 2008.		* 4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service Licensee	Cemete	ry 2005 22. Name and Address of Facility icks Home for Fund		orth East, Maryland
ä	Depariment Department of the suny in s		1 Done & H	eter 10	03 W. Stockton St	reet, Elkt	con, Maryland 21921
			23a. Part1. Enter the disease, or complications the shock, or heart failure. List only one cause of	at caused the death. Do not er	nter the mode of dying, such as cardiad	or respiratory arrest	t, Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	END STAGE	LUNG DISEASE		Onder and Death
ŝe	/Medical Examiner		Due	to (or as a consequence of):			
II,		ner	Sequentially list conditions, if any, leading to immediate cause. Litter Underlying	to (or as a consequence of):			
V	ecuted and transi	Examiner	that initiated events c.	to (or as a consequence of):			
68760,	ificate be executed g physicien end as the burial-transit	ai E)	Due	to (or as a consequence or).			
687	ificate g phys as the	edicai	O				
Box	death certii e attending id for use a	an/M		outcome of pregnancy /e birth 2 Petaf death 3	☐Ectopic pregnancy		23d. Date of delivery  Month Day Year
о. П	0 0	by Physician/M	1 Ves 2 No	egnant at time of death 5: nknown	Other (specify)		Worth Day 76a
Δ.	The law requires that the ste has been signed by the bage 2 should be detache	y Ph	Part II. Other significant conditions contributing to	o death but not resulting in the	underlying cause given in Part I.	23e. Did toba	cco use contribute to the cause of death?
rds	quires in sign					1 ☐ Yes	2 No 3 Probably 4-Onknown
000	law reas bee	Completed				24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
Ä	The cate h	Com				performe	death?
Vital Records,	Physician: r this certifica ral director, I	Be	25. Was case referred to medical examiner?			ath (Check only one)	
of	Phys eral di	n: To	27. Manner of Death 28a. Da	□ Inpatient 2 □ ER/Outpatient 2 □ ER/Outpatient 2 □ ER/Outpatient 28b. Time Injury	of 28c. Injury at	28d. Describe how	ce 6 Other (Specify) rinitury occurred
ion	Attending ir death. ector: After by the fune	atio	2 Accident investigation	Injury	Work? M 1 ☐ Yes 2 ☐ No		
Division of	To the Hospitel or Attending Physician: The law within 24 hours efter death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 286 Pla	ace of fnjury - At home, farm, suilding, etc. (Specify)	street, factory, office	28f. Location (Stree City or Town,	et and Number or Rural Route Number, State)
	Hospitel		29a, Certifier 1 □ sertifying Physica 1 To	# e best of my knowledge, dea	ath occurred at the time, date and place	a, and due to the cau	se(s) and manner as stated.
	n 24 h n 24 h he Fur bietely	Medical	(Check only 2 Medical Examination that one)	b basis of examination and/or in anner stated.	ath occurred at the time, date and place investigation, in my opinion, death occu	urred at the time, date	e and place, and due to the cause(s)
	To the within 2 To the complet	ž	29b. Signature and title of certifier		29c. License number	290	d. Date signed (Month, Day, Year)
•	امن		/11/19/	L~	אטויכע / כ	20	DAPLOS
	671		30. Name and address of person who contributed o	ause of death (Item 23a) (Type	~ a 1/=	NCASTLE	DE 19720
	Sta	te		2. Registrar's Signature	4-0-		7
	Registr	ar	<b>APR 2 6 2005</b> □	Bloom & K. A.	Social D		

DHMH 17 Rev 1/2001

ORIGINAL

Gina Marie Bell 05**-**2699 AKG

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Physic	ion	1. Decedent's Name (First, Middle, Last,	Gina Marie I	Bell		_	2. Date of Dea Month		Year	3. Time of Death
/Medi							April	<del></del>	05°	8:30 AM
Exami	ner	4a. Facility Name (If not institution, give 17313 Laurel Run Ro			4b. City, Town, or Barton	Location of Dea	th	4c. County Alleg		
Funeral		5. Social Security Number 6. Sec		. last birthday)	If Under 1 Year Months Days	If Under 24 Hr. Hours Mir				ace (State or Foreign
Director			M 2 🕱 F 39	Yrs.	Months Days	Hours Mir	October			nnsylvania
land		Usual Residence of Decedent  10a. State 10b. County	10c. C	ity, Town or Lo	cation				10	d. Inside City Limits
Mary B-f sh	ţċ	Maryland Alle	gany			Barton				1 ☐ Yes 2 No
within 72 hours after death with the Maryland ene. then "naturel", or items 23e or 28e-f show he Medical Evantiner must be notified at	I Director	10e. Street and Number 17313 Lau	rel Run Road		10f. Zip Code	21521	1	10g. Citizen of V	What Count USA	
death	Funeral	11. Marital Status	12. Was Decedent Ever in I Armed Forces?	U.S. 13.	Was Decedent of H	ispanic Origin? (	Specify Yes or No- rto Rican, etc.)	14. Rac	e - America ck, White, e	
all, or ite	þ	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 Ø Divorced	1 Yes 2 No If Yes, Give Year or Dates:	ŀ	1 ☐ Yes 2 🛣 No	Specify:	TO THOUS, GOO,	Specify		White
natura	eted	15. Decedent's Edu (Specify only highest grad	cation e completed)	(Give	dent's Usual Occupa	durina most of w	orking	16b. Kind of B	usiness/Ind	ustry
hen "	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life. I	DO NOT use retired	Labor			Bline	ds
Hygie Dther ent,	Be Co	17. Father's Name (First, Middle, Last)				18. Mother's Na	me (First, Middle,			
uld ba Mental Mrked rrked	To B	I	Billy Sam Bell				Jacque 	line Conso	onery	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 Is marked other then "naturel", or items 23a or 28e-1 show any injury or other traumatic event, the Medical Examinat must be notified at ance.  Once.	ľ	19a. Informant's Name/Relationship (T) Jacqueline J. Samu	rpe, Print) aels-Mother	19b. Mailir			lural Route Number oad, Gautier, N			Code)
ss 1 and 2: of Health ai litem 27 is r other trau		20a. Method of Disposition	1	Place of Dispo cemetery, cren	sition (Name of natory or other place	:e)	Date April 19,	20c. Location -	City or Tov	wn, State
ment ment tant: It		1 ☐ Burial 2 ☐ Cremation 3 ☐ F `4 ☐ Donation 5 ☐ Other (Specify)		Cumbe	erland Cremato	ory	2005	Cumb	erland, N	Maryland
Depart Import any in		21. Signature of Funeral Service Licens	99		2. Name and Address ichhorn-McKe		Home 8 East	Main St., L	onaconin	rg, MJ. 21539
*	1	23a. Par 1. Enter the disease, or complete ock, or heart failure. List only o	ications that caused the dea							Approximate Interval Between
hysician	П	Immediate Cause (Final disease or condition	Bupropion A	nd Tram	adol Into	xicatio	1			Onset and Death
/Medical Examiner		resulting in death)	Due to (or as a conse	equence of):						
≫	er	Sequentially list conditions, if any, leading to immediate cause. Enter Under vin	Due to (or as a conse	equence of):						
cutad nd ransit	Examiner	that initiated events	c							
icate be executed physician and s the burial-transit	EX	resulting in death) Last	Due to (or as a conse	equence of):						
death certificate be executad e attending physician and id for use as the burial-transit	edical		d							
attending p	Physiclan/Me	23b. was decedent pregnant	23c. If yes, outcome of pregr 1 □ Live birth 2 □ Fe		Ectopic pregnancy	,			te of delive	•
	sicla	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4☐Pregnant at time of 9☐Unknown		Other (specify)			Mo	nth	Day Year
ed by the detachad	, Phy	Part II. Other significant conditions co	ntributing to death but not re	sulting in the u	nderlying cause give	en in Part I.	23e. Did to	bacco use cont	ribute to the	e cause of death?
n signed	d by						1 □ Y	es 2□No	3 Proba	ably 4 Minknown
ina iaw requiras inat ine ite has baen signed by th bage 2 should be detachs	Completed						24a. Was a autops	an 24b.	Were autop	sy findings available
	Com						perform 1 Yes	med?	death?	2 No
rnysician: In this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:		oth		ath (Check only or			
d is	- T	1 XYes 2 No 27. Manner of Death	1 ☐ Inpatient 2 [ 28a. Date of Injury	BR/Outpatier	IL SU DOX	4 🗆 Hursing	Home 5 Residence 128d. Describe he			at scene
or Attending after death. Director: After in by the funer	Certification:	1 □ Natural 5 □ Pending 2 □ Accident investigation	Formal Pay Year)	28b. Time of <b>Found</b> 8:15	A M 1	k? Yes 2∭∑No	Subject			olets
I or Attendi after death. Director: A I in by the fu	tifle	3 Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At building, etc. (Spec	home, farm, str	eet, factory, office		28f. Location (S. City or Town	treet and Numb n, State) 173	er or Bural	Route Number, Irel Run I
0 # C =			Scene				Barton,	Md		
urs urs sral	edical	29a. Certifier 1 Certifying Phy (Check only 2 Medical Exami	sician: To the best of my kr ner: On the basis of examir and manner stated.	nation and/or in	vestigation, in my o	ne, date and place pinion, death occ	e, and due to the curred at the time, d	ause(s) and ma late and place,	anner as sta and due to	the cause(s)
e Hospitel 24 hours a 8 Funeral letely filled	0	29b. Signature and title of certifier			29c. License			9d. Date signe		
4 hours 4 hours 4 uneral	Σ				OCM		I A	Thirt To	, 20C	, ,
within 24 hours  To tha Funeral  completely filled	Σ	> Une 15			OCME					
To the Hospitel or within 24 hours after To the Funeral Directory Completely filled in I	W	30. Name and address of person who c		эт 23а) (Туре,	Print)		D 7		3.6	land 2120

State of Maryland / Department of Health and Mental Hygiene 2 0 5 For State Registra Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Physician April 16 2005 2235 Iva Lorraine Cohen /Medical 4c. County of Death 4b. City, Town, or Location of Death 4e. Fecility Name (If not institution, give street and number) Examiner Cecil Calvert Manor Nursing Home Rising Sun If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** Months Days Hours 1 M 2 B 6/6/15 Florida Director 265-24-0685 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show other traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Havre de Grace Director MD Harford 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21078 U.S.A. 4130 Webster Road by Funeral 14 Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. Peges 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. ont: If item 27 is marked other than "natural", or Ita 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2√2 No Specify: Specify: Baltimore, Maryland 21215-0036 3 ₩ Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker In home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ပ Maude Roberts Wesley L. Andrews 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Merrill Cohen (Son) 4130 Webster Road, Havre de Grace, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Peges 1
Department of H
Importent: If ite
any injury or ot
once. 1 ☐ Burial 2 ☑ Cremation 3 ☑ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) R. A. Ferris & Co. 4/19/05 West Chester, PA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Tarring-Cargo Funeral Home, P. Aberdeen, Maryland 21001-3399 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition ementia **Physician** resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner attending physicien and for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Dav in the past 12 months? 4□Pregnant at time of death 5 Other (specify) 1 ☐ Yes 20€ No the 9 Unknown signed by t d be detact 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 20 No 1 ☐ Yes 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes & No has page 25XN0 1 Yes certificate or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 Inpatient Other: 1 ☐ Yes 2 No Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 ER/Outpatient 3 DOA 2 this 28b. Time of 28c. Injury at Work? 27. Manper of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Certification: After Natural 2 Accident 5 Pending Injury 1 Tes 2 No investigation 6 Could not be determined 3 ☐ Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide within 24 hours a To the Funeral C Cartifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier 18/05 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 281 E. Main St., Rising Sun, MD 21911 Muhammad Jokhadar, M.D. 32. Redistrar's Signature 31. Date filed (Month, State Registrar

	<b>.</b>	•	State of Maryl  1- State of Maryl  negligistrar amended per dr./item					giene Reg. No. ()	)5	161
			Decedent's Name (First, Middle, Last)				2. Date of Dea	ath Day	Year	3. Time of Death
	Physici: /Medic		Shirley Marie Cranf	ield			April			10:40 a
	Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of De	ath	4c. Count	ty of Death	
			7929 Naas Road		Salisbu				omico	
	Funeral		1 □ M 2 🕅 F	yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 H Hours Mi	n. (Month, Da	y, Year)		ace (State or Foreign
	Director		214-46-4754 59 Usual Residence of Decedent				10/2/19	945	Mary	land
	/land		The state of the s	. City, Town or Lo	ocation				10	d. Inside City Limits
	Mar.	햦	Maryland Wicomico	Salisbu	ry					1 ☐ Yes 2 No
	or 28	ire	10e. Street and Number		10f. Zip Code			10g. Citizen of		ry?
	23a	Funeral Director	7929 Naas Rd.		21804			USA		
	er deg	nue	11. Marital Status  12. Was Decedent Ever Amed Forces?	in U.S. 13.	Was Decedent of H If Yes, specify Cuba	lispanic Origin? an, Mexican, Pu	(Specify Yes or No- erto Rican, etc.)		ace - America ack, White, e	
36	rs after	by F	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		1 ☐ Yes 2€ No	Specify:		Spec	ity: wh	nite
우	d within 72 hours after death with the Maryland jiele. r than "natural; or Iteme 23a or 28a-f ehow The Madical Exterilizational be notified at		15. Decedent's Education		dent's Usual Occup			16b. Kind of I	Business/Indu	ustry ·
715	within 72 ene. than "n	plet	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)	life.	kind of work done of DO NOT use retired	dunng most of v d)	vorking	Penins	ula Re	egional
21	giene. grene. er ther	Completed	12 –	Lin	en Aid			Medica		er
Maryland 21215-0036	be filed ital Hygie d other	Be (	17. Father's Name (First, Middle, Last)				lame (First, Middle,		ime)	
yla		은	Wilbur Clifford Austin	401-14-11			Marie Shoo Rural Route Numbe		n State Zin (	Codel
Mar	12 sho h and 7 Is m Iraum		19a. Informant's Name/Relationship (Type, Print)  Vaughn C. Cranfield/husband				sbury, MD		i, State, Zip t	2008)
di.	s 1 and 2 should f Health and Mer item 27 is marke other traumatic			Ob. Place of Dispo	osition (Name of	-	Date Date	20c. Location	- City or Tov	vn, State
nor	ages ant of tt: # it		1 ▼Buriai 2 □ Cremation 3 □ Removal from State  1 □ Donation 5 □ Other (Specify)	Springhi	matory or other place 11 Memory		14/2005	Hebr	on, MD	)
Baltimore,	permit. Pages 1 Department of H Important: if ite any injury or ot ance.		11 Signatura of Funeral Service Licensee		2. Name and Addre	ss of Facility				
ñ	Per p	k ti	Navic tr. Compson	FSP 5	Olloway E 01 Snow E	uneral Hill Rd.	Home Prot , Salisbu	tession urvMD	al Ass 21804	ociation
			23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line.	death. Do not en	ter the mode of dyir	ng, such as card	liac or respiratory a	rrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	tie	Brees	1 (0	nace		10	Onset and Death
	/Medical Examiner		resulting in death)  Due to (or as a co	nsequence of):						7
	LXammer	<u>.</u>	Sequentially list conditions, b. Due to for as a co	nse tience off:					-	
	ted nsit	nlne	cause. Enter Underlying Cause (Disease or injury	nad gas nod otg						
	al-tra	Examine	that initiated events resulting in death) Last C. Due to (or as a co	nsequence of):						
8760,	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the buriat-transit	call	d							
9	tificat ng phy as th	Physiclan/Medical	The mental of					1		
Вох	leath certifica attending ph for use as th	an/N	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □		☐Ectopic pregnancy	y		2	ate of deliver	ry Day Year
	ie dea the att	sicl	in the past 12 months?  1  Yes 2  No	of death 5[	Other (specify)					,
P.0	that the ded by the	Phy	Part II. Other significant conditions contributing to death but no	it resulting in the	underlying cause giv	ven in Part I.	23e. Did t	obacco use co	ntribute to the	e cause of death?
S,	ires tha signed d be det	l by	Tarrin Strict Significant Contactions Contacting to Country Strict				1 🗆	Yes 20 No	3 🗌 Proba	ably 4 Unknown
Ö	w requir been si should	etec					24a. Was	an 24b	. Were autop	osy findings available
Records,	The law ste has page 2.	Completed						rmed2	death?	npletion of cause of
Vital	ician: Th certificete rector, pag	e C	25. Was case referred to medical			26. Place of I	1 Yes	one)	1 1 1 1 1 1 1	22,140
>	Physician: this certific ral director,	0 8	examiner?	2 ER/Outpatie	int 3□ DOA Oth	ner: 4 🗆 Nursin		dence 6 🗆 O	ther (Specify,	)
J of	ding Phys	n: T	27. Manner of Death 28a. ate of Injury (Month, Day Ye	ar) 28b. Time o	Wo	rk?	28d. Describe	how injury occ	urred	
Sion	Attanding ir death. actor: After by the fune	catlo	2 ☐ Accident investigation			Yes 2 □ No				
Division	after de Diract	Certification;	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury building, etc. (S	At home, farm, si pecify)	treet, factory, office		28f. Location ( City or To	Street and Nur wn, State)	nber of Hurai	Route Number,
	Hospital  24 hours a  Funaral D  tely filled i		29a. Certifier Certifying Physician: To the best of m	v knowledge dea	th occurred at the ti	me date and pl	ace, and due to the	cause(s) and i	manner as sta	ated.
	To the Hospital or Attanding Physician: The I within 24 hours after death.  To the Funaral Director: After this certificate he completely filled in by the funeral director, page	Medical	(Check only 2 Medical Examiner: On the basis of examiner)	imination and/or i	nvestigation, in my	opinion, death o	ccurred at the time,	date and place	e, and due to	the cause(s)
	To the within 2 To the Comple	Me	29b. Signature and title of certifier	AND	29c. Licens	se number		29d. Date sign		
	)		Wall of the second	VV	Do	262	78	4-	- 13-	-05
	/W		30. Name and address of person who completed cause of death	(Item 23a) (Type	Print)	172	2 0	Lel	MA	21602
	1		31. Date filed (Month, Day, Year). 32. Registrar's	HOSPKE Signature	1.0.10	x //3	) (50)	listo	7	21100
	St Regist	ate trar	APR 14 2005	1. 1.	berle			$\mathcal{O}$	·	

			1- State of Maryland / Departm	ent of Health and Neate of Death	Mental Hygie	2003	1 62
		m	Decedent's Name (First, Middle, Last)		2. Date of Death		3. Time of Death
	Physicia /Medic		ANNIE L. C. CHAPMAN		APRIL 9	2005	2:06 P M
	Examin			City, Town, or Location of Death		4c. County of Death	
			WASHINGTON ADVENTIST HOSPITAL	TAKOMA PARK		MONTGOMERY	
	Funeral Director			Inder 1 Year If Under 24 Hrs. Iths Days Hours Min.	8. Date of Birth (Month, Day, Ye January 1	ear) Cou	place <i>(State or Foreign</i> ntry) rth Carolina
٦	D		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location				I0d. Inside City Limits
	short all	'n	, , , , , , , , , , , , , , , , , , , ,				11 Yes 2 No
	the N	ect	MD PRINCE GEORGE'S LANDOVER  10e. Street and Number 10	HILLS f. Zip Code	100	Citizen of What Cou	A
	3a or	Funeral Director	4005 70th AVENUE	20784	103.	U.S.A.	
	death ms 2	Jera		Decedent of Hispanic Origin? (Sp specify Cuban, Mexican, Puerto	pecify Yes or No-	14. Race - Americ	
020	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importment if them 27 is marked other than "netural", or items 23a or 28a-f show any injury or other treumatic svent, if a Medical Evacin at most be notified at once.	by	1 ☐ Never Married 2K Married 1 ☐ Yes 2 🛱 No	specify Cuban, Mexican, Puerto	Hican, etc.)	Black, White, Specify:	etc. Black
	72 ho	Completed	15. Decedent's Education 16a. Decedent's (Specify only highest grade completed) (Give kind	Usual Occupation	king 16t	. Kind of Business/In	dustry
V	ithin se	npie	Elementary/Secondary (0-12) College (1-4or 5+)	of work done during most of wor OT use retired)			
7	led w tygier her th		4 yrs Budg	get Analyst	ne (First, Middle, Maid	Governm	ent
5	I be fi ntal H ed ot	Be	Will McKinley Hendricks		el Cherry	den Sumame)	
<u></u>	thoutch d Me mark matic	오		ity or Town, State, Zip	Code)		
Ξ	ad 2 s lith ar 27 is r treu	ı		sletoe Spring			
ה ת	s 1 ar		20a. Method of Disposition  20b. Place of Disposition  cemetery, crematory	(Name of	Date 200	. Location - City or To	own, State
	Page nent c int: If iry or		1 ⊈Burial 2 □ Cremation 3 □ Removal from State  '4 □ Donation 5 □ Other (Specify)  Maryland Na		/05 La	aurel,Mary	land
<u> </u>	permit. Departn Importe any inju				. B. Jenk		
٥	89 = 9			Landover Road			20785
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the shock, or heart failure. List only one cause on each line.	1 - 0	_		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	LIVER DISE			Onset and Death
	/Medical Examiner		Due to (or as a consequence of):	CARCINOM	a of cr	201	
	And Add	-	Sequentially list conditions, if any, leading to immediate b.  Due to (or as a consequence of):	Chocallon		V . V	
	uted ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events  C			(4)	
ĵ.	exec an and rial-tra	Еха	resulting in death) Last  Due to (or as a consequence of):				
0/00,	cate be executed physician and the burial-transit	dicai	d				
0	artifica ing ph e as t	Med	IF FEMALE:				
. 0	The law requires that the death certifi ate has been signed by the attending page 2 should be detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?	oic pregnancy or (specify)		23d. Date of deliver	ery Day Year
ŗ	that the by detail		Part II. Other significant conditions contributing to death but not resulting in the underly	ing cause given in Part I.	23e. Did tobac	co use contribute to t	he cause of death?
2	quires n sign	ed by	OBSTRUCT VE JAVADICE, LIVER FA		1 ☐ Yes	20 No 3 □ Prot	babły 4 🗆 Unknown
necolus,	s bee	Completed	ENCOPHALOPATHY, ENDSTAGE DEN	M DISTAGE,	24a. Was an		ppsy findings available
ב	Physicien: The faw r this certificate has b rral director, page 2 s	mo	DIABETES MELLINS, OSESITY		autopsy performed 1 Yes 2 2	death?	mpletion of cause of 2 No
E	stiffica ctor, I	Bec	25. Was case referred to medical examiner?	26. Place of Dea	th (Check only one)		
5	hysic this co	2	1 ☐ Yes 2 ☐ No Hospital: ☐ Impatient 2 ☐ ER/Outpatient 3		ome 5 Residence		(y)
=	ding Ph h. After th funeral	ion:	27. Manner of Death  Natural 5 □ Pending  28a. Date of Injury (Month, Day Year)  28b. Time of Injury	28c. Injury at Work?	28d. Describe how i	njury occurred	
UNISION	ttend death stor: , the f	icat	2 Accident investigation 3 Suicide 6 Could not be determined could not be determined.	4	28f Location (Street	t and Number or Run	al Pouta Number
2	lor A after Direct	Certification:	4 Homicide determined building, etc. (Specify)	ictory, onice	City or Town, S		ar riodio riastibor,
	To the Hospitel or Attending Physicien: white 24 hours after deals, as the feath his certificator. After this certification the Funeral Director. After the completely filled in by the funeral director.		29a. Certifier Certifying Physician: To the best of my knowledge, death occur	urred at the time, date and place	, and due to the caus	e(s) and manner as s	tated.
	he Ho in 24 he Fu pletel	edical	(Check only one)  2 Medical Examiner: On the basis of examination and/or investig and manner stated.	ation, in my opinion, death occu	rred at the time, date	and place, and due to	o the cause(s)
	within com	Σ	29b. Signature and title-of certifier  **L' SWWW FWW FWW  **Comparison of the certifier of	29c. License number		Date signed (Month,	Day, Year)
2	(3)		30. Name and address of perlin who completed cause of death (Item 23a) (Type, Print)	202, Garth	ers burg,	Mp: 200	ets.
	Sta		31. Date filed (Month, Day, Year)				
8	Registr	ar	APR 13 2005 Beau & Start	,			

			For State Registrar	State	of Maryla	and / Depa <i>Cei</i>	artment of rtificate of	Health Death	and M		giene Reg. No.	005	entitions entitles en	53		
Phy	ysicia	an	1. Decedent's Name (First, Mid							2. Date of De Month		Year	3. Time of D	eath		
//	/ledic	al			STORR		4 C: T		15 11	APR		005 Year	3:46 I	) м		
Ex	amin	er	4a. Facility Name (If not institute NATIONAL NAV	-		ZR	4b. City, Town,	or Location HESDA				County of Dea				
Fun	oral		5. Social Security Number	6. Sex		rs. last birthday)	If Under 1 Yea	r If Under	24 Hrs.	8. Date of Bir (Month, Da			thplace (State or	Foreiar		
Dire			366-07-8557	1 💢 M 2 🗆 F		92 Yrs.	Months Days	Hours	Min.	(Month, Da 11/18/		Co	chigan			
put	1500		Usual Residence of Decedent 10a. State 10b. Coun	tv	100	City, Town or Lo	ecation						10d. Inside City	Limita		
Aaryla Fehor	n Pa	ō		gomery		ethesda	Cation						1 X Yes 2			
the 1	Hou	Director	10e. Street and Number	30mer y	Di	etnesda	10f. Zip Code				10g. Citiz	zen of What Co	ountry?			
h with	at Le		7431 Crestbern	y La.			208	17				USA	,			
5-0036 72 hours after death with the Maryland neturel', or items 23e or 28a-f ehow	RE COM	Funeral	11. Marital Status	12. Was De	cedent Ever in	n U.S. 13.	Was Decedent of If Yes, specify Cu	Hispanic Or ban, Mexica	rigin? (Spe	cify Yes or No	- 1	4. Race - Ame Black, Whit				
36 s afte	of the	by Fu	1 Never Married 2 M	arried 1 Ves	2 □ No Give		1 ☐ Yes 2 ☑ No					C:				
hour le	Sal Ev		3 Widowed 4 Divorce	ent's Education	Dates:	16a Dece	dent's Usual Occi	ination				MI and of Business	nite			
715 and 72 and 7	Medic	piet		est grade completed	(1-4or 5+)	(Give	kind of work done DO NOT use retir	during mos	st of workir	ng	100.10	id of Dusifiess	middstry			
nd 2121 e filed within al Hyglene.	2	Completed	Liamontaly/Socondary (o 12	5+	(1-401-54)	Of	ficer				US	Army				
Pe iii	eveni	Be	17. Father's Name (First, Middle	e, Last)						(First, Middle,		Sumame)				
Tyla Tyla Men Men Men	natic	O.	Romeo Castorri	anhia (Tima Baias)		10h M-10		1		Fiore						
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "neturel", or items 23e or 28e-1 ehow	traur		19a. Informant's Name/Relation				ng Address (Stree						Zip Code)			
S 1 ar f Hea	other					o. Place of Dispo	sition (Name of		Darra	ate Tex			Town, State			
Page nent o	ry or	20a. Method of Disposition    Burial   2   Cremation   3   Removal from State   20b. Place of Disposition (Name of cemetery, crematory or other place)   4   Donation   5   Other (Specify)   Arlington National   6/29/05														
Baltimore, permit, Pages 1 ar Department of Hea	eny inju once.		Arlington National  2 Commation 3 Hemoval from State  4 Donation 5 Other (Specify)  Arlington National  22. Name and Address of Facility  Murphy Funeral Home 4510 Wilson Blvd.													
<b>0</b> 85 <b>E</b>	2 A		23a. Part1. Enter the disease, phock, or heart failure. Li	Macen	plus			rling	ton.	VA 22	203	son BIA	d.			
Wed Exami Example Examine Examine Examine Examine bhysician and Examine Physician and Example	ical iner	dicai Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Lusause or in the part initiated events resulting in death) Last	aI Due to  b Due to	PNEUMON o (or as a cons o (or as a cons o (or as a cons	Sequence of):							Interval Betwee			
.O. Box 6 the death certiful y the attending	be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1□Live	outcome of preparation in the preparation of the pr	etal death 3	]Ectopic pregnand ] Other (specify)	су			2	3d. Date of del Month	ivery Day Ye	ar		
ords, P requires that een signed b		by	Part II. Other significant condi	tions contributing to	death but not i	resulting in the u	nderlying cause g	ven in Part I	l.	23e. Did to	τ.	7	the cause of dea			
I Rec The taw ate has b	page 2 should	Completed								24a. Was autop perfo		prior to death?	itopsy findings av completion of cau	ailable se of		
of Vital F Physicien: Th this certificate	rector,	Be	25. Was case referred to medic examiner?						e of Death	(Check only o						
on of ding Phys h,	funeral di	tlon: To	1 Yes 2 Xo  27. Manner of Death 1 Xuatural 5 Pend 2 Accident inves	28a. Dat	Inpatient 2 e of Injury onth, Day Year,	ER/Outpatien 28b. Time of Injury	28c. Inju		2	ne 5 🗆 Resid 8d. Describe f		Other (Spec	cify)			
Division Hospitet or Attending Party hours after death. Funerei Director: After	completely filled in by the	Certification;	3 ☐ Suicide 6 ☐ Coul	d not be 28e. Plac	ce of Injury - A ding, etc. (Spe	t home, farm, str	eet, factory, office		2	8f. Location (S City or Tox		Number or Ru	iral Route Numbe	r,		
	pletely filli	edical	29a. Certifier 1 X Artify (Check only one) 2 Medical	ring Physician: To the all Examiner: On the and ma	ne best of my k basis of exam inner stated.	knowledge, death ination and/or in	n occurred at the t vestigation, in my	ime, date ar opinion, dea	nd place, and the occurre	nd due to the d d at the time,	cause(s) a	and manner as place, and due	stated. to the cause(s)			
To the within 2	COLL	Σ	29b. Signature and title of certif	ier in O		200	29c. Licen	se number				signed (Montl	h, Day, Year)			
Til		(de	MZ. N	illea	us 1	"VLL"		20755			APR	8 2005				
1	/		30. Name and address of person		use of death (I	tem 23a) (Type,	Print)			AVAL MID 2088		AL CENT	ER			
	Sta	te	A. L. WILL  31. Date filed (Month, Day, Yea		Registrar's Sig	gnature		DEINE	SUA IM	D 2008;	J-36(	<i>,</i> 0				
Re	gistr		APR 13	2005	tue 1	gnature &	de la									

			1 - For State Registrar	State of M	larylaı				lealth ar Death	nd Me		jiene	005	4.5	64
	Physici		1. Decedent's Name (First, Middle, I Suzanne Tryfu	,						2.	Date of Dea Month April	Day	Year 005	3. Time o	of Death
	/Medic Examir		4a. Facility Name (If not institution, g Suburban Hospi	tal			В	thes			•	4c. Co	unty of Dear		
	Funeral Director		052-58-0893	Sex 7. Ag 1 ☐ M 2 ☐ XF	ge (In yrs 85	. last birthday, Yrs.		er 1 Year s Days		Min. 8.	Date of Birth (Month, Day 10/25/	Year) 1919	9. Bird Co Ge 1	thplace (State ountry) rmany	ar Fareign
	show	or	Usual Residence of Decedent  10a. State 10b. County		10c. C	ity, Town or L								10d. Inside C	City Limits
	th the Nor 28a-1	Director	MD Montgon	ery		Bethe		ip Code			1	0g. Citizer	of What Co		
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mentat Hygiene. Importent: if item 27 is marked other than "natural; or items 23a or 28a-f show any injury or other traumatic event, it a Medical Examinating the rediited at Once.	by Funeral	5454 Whitley P  11. Marital Status  1  Never Married 2 Married 3  Widowed 4 Divorced	12. Was Decedent Armed Forces	Ever in l		Was Dec	20814 edent of F ecify Cub: 2X No	lisp <i>a</i> nic Origin an, Mexican, F	n? (Specifi Puerto Ric	y Yes or No- an, etc.)	ĺ			
1215-0	vithin 72 ho ne. han "natur ne Medical	Completed	15. Decedent's (Specify only highest of Elementary/Secondary (0-12)	rade completed) College (1-4or	5+)		e kind of v DO NOT	vork done use retire	oation during most o d)	of working		16b. Kind	of Business	/Industry	
Marvland 21215-0036	ld be filed v entat Hygie ked other ti Ic event, to	To Be Co	17. Father's Name (First, Middle, La. Dr. Frederick			Tran	SIAL	or			First, Middle, i n Tryfi	Maiden Su		ent	-
Mary	12 shou h and M 7 is mar rraumati	-	19a. Informant's Name/Relationship	(Type, Print)					and Number	or Rural R	Route Number	r, City or To		Zip Code)	
ore.	ges 1 and 1 of Healt if item 2 or other		Danielle Smotkir  20a. Method of Disposition  1  Burial 2 □ Cremation 3		20b.	Place of Disp	osition (A	ame of	e Lane	Date		20c. Locat	ion - City or	Town, State	
Baltimore.	mit. Pag partment portent: / injury		* 4 □ Donation 5 □ Other (Spec 21. Signature of Funeral Service Lic	eify)	Ğa	cemetery, cre ng Dav rdens				/10/2				ch, VA	
œ			23a. Part1. Enter the disease, or co	Kudli	WE	Z R	anza ockv	nsky- ille	ess of Facility Goldbe Pike,	rg Me Rock	emoria ville,	MD 2	Bels,	Approxima	
.8760.	requires that the death certificate be executed WA Washington and would be detached for use as the buriat-transit	dicai Examiner	shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause that understanding Cause (Disease or injury that initiated events resulting in death) Last		ve B	quence of):	al P	leura	ıl Effu	sions	S			Interval Be Onset and	Iveen Death
~/ <i>E</i> .0. Box 6	Ithe death certific by the attending parached for use as t	hysiclan/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2   Fet	aldeath 3	⊒Ectopic ⊒ Other (	pregnancy specify)	y			23d	. Date of deli Month	-	Year
ANN Bs. P.O.	uires that signed b	by P	Part II. Other significant conditions Anasarca	contributing to death b	out not re	sulting in the u	underlying	cause giv	ren in Part I.			oacco use		the cause of obably 4	
N	:. The law requicele has been ; page 2 should	ompleted								_	24a. Was a autops perforc	V	prior to death?	itopsy findings completion of c	available ause of
Sital S	sician: certifice rector, p	BeC	25. Was case referred to medical examiner?	Magnitali							check only on	e)			
7000	g Physie refer this control direction	: To	1 ☐ Yes 2 XNo  27. Manner of Death	Hospital: 1 🗶 Inpati-		ER/Outpatie	-	28c. Injur	v at		5 Reside			cify)	
RIC Islon	를 근통 글	atlor	1 X Natural 5 ☐ Pending investigate	on	ay Year)	Injury	М	28c. Injur Wor 1 🔲	k? Yes 2□No						
TAR DIVIN	in Direct	Certification:	3 Suicide 6 Could not 4 Homicide determine		jury - At h tc. <i>(Speci</i>	nome, farm, st	reet, facto	ory, office		28f.	Location (St. City or Town	reet and N n, State)	umber or Ru	ıral Route Num	iber,
T T	To the Hospitel within 24 hours a To the Funeref I completely filled	edical	29a. Certifier (Check only one) Certifying I	Physician: To the best aminer: On the basis o and manner st	of examin	owledge, deat ation and/or in	th occurre	d at the tir on, in my o	me, date and p pinion, death	oiace, and occurred a	due to the ca at the time, da	ause(s) and ate and pla	manner as ce, and due	stated. to the cause(s	5)
	To the To the comp	ž	29b. Signature and title of certifier				2	9c. Licens	e number		25	9d. Date si	gned (Month	n, Day, Year)	_
	10		30. Name and a dress person wh	completed cause of	death (Ite	m 23a) (Type,		D0061	302		A	pril	7, 200	05	
			Atul Rohatgi, M.	D., 8600 C			own	Road,	Bethe	sda,	MD 20	814			
	Sta Registr		31. Date filed (MontAPRY1) 2	2005	ar a aign	1. 4	books								

		1	For State Registrar	State of Mai	ryland / Depa <i>Cei</i>	artment of H		-	giene	)5	14167
	Physicia		1. Decedent's Name (First, Middle, Last)					2. Date of De	Day	Year	3. Time of Death
	/Medic	al	Paul G. Clark  4a. Facility Name (If not institution, give s	treet and number)		4h City Town or	Location of Death	04	4c Count	y of Death	19.49 1
	Examin	91	SACRED HEART	HOSPITAI	_		SERLAND	`		EG	VAA
	Funeral Director		5. Social Security Number 6. Sex		(In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da 02-Jan-			place (State or Foreign oftry)
	pu ,	i -	Usual Residence of Decedent		10a City Tarrant						
	faryla show				10c. City, Town or Lo <b>Frostburg</b>	cation					10d. Inside City Limits 1 ☐ Yes 2 → No
	the A 288-1	Director	Maryland Garrett  10e. Street and Number 1042 Eigen		riostotig	10f. Zip Code			10g. Citizen of	What Cour	
	3a or	Ö	1042 Finze	ROAG		21532-			U.S.A.		,
Maryland 21215-0036	d within 72 hours after death with the Maryland jiene. r than "natural", or Items 23a or 28a-f show the Madical Examiliar must be mailited at	by Fur	11. Marital Status  1 Never Married 2 A Married  3 Widowed 4 Divorced	12. Was Decedent Ev Armed Forces? 1 ☐ Yes 2 12 No If Yes, Give Year or Dates:	,	Was Decedent of Hi	ispanic Origin? (Spann, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)	- 14. Ra	ce - Americack, White,	etc.
5-0	72 hc	eted	15. Decedent's Edu (Specify only highest grade		(Give	dent's Usual Occupa	during most of worki	na	16b. Kind of E		
121	within ene. than "	Completed	Elementary/Secondary (0-12)	College (1-4or 5+	)	DO NOT use retired	()		tire man	ifootiir	ear.
0	Hyg than int,	e Co	12 2 17. Father's Name (First, Middle, Last)		machi	nist	18. Mother's Name	(First, Middle			CI
an	d ta d	To Be	James Clark				Anna Pearl			,	
ary	2 should be and Mental ie marked aumatic ev	-	19a. Informant's Name/Relationship (Ty	oe, Print)			and Number or Rura			, State, Zip	Code)
	1 and 2 Health a tem 27 ie		Evelyn Wilhelm Clark	wife	1042 F	inzel Road	Frost	burg	Mary	land	21532
ore	of He		20a. Method of Disposition  1   Burial 2 □ Cremation 3 □ P	emoval from State	20b. Place of Dispo cemetery, crei	sition (Name of natory or other plac	e)	ate	20c. Location	- City or To	own, State
Ë	Pagas tment of tant: If it jury or o	-	`4 □Donation 5 □ Other (Specify)		Finzel Ceme	tery	08-A	pr-2005	Finzel	M	aryland
Baltimore,	permit. Pagas 1 and 2 should Department of Health and Men important: if item 27 ie marke any injury or other traumatic page.		21. Signature of Funeral Service License	Durch		2. Name and Address Irst Funeral	ss of Facility Home, 57 F	rost Ave.	, Frostbur	g, MD	21532
	/Medical Examiner points to private the pr	Examiner	shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a		RAL	BLERDIN	72			Interval Between Onset and Death Onset and Death
P.O. Box 68760,	at the death certifica by the attending ph tached for use as th	Physician/Medicai	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	3c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at ti 9 □ Unknown	Fetal death 3		23d. Da	ery Day Year			
	ires tha signed t be de	by	Part II. Other significant conditions con	tributing to death but	_	nderlying cause give	en in Part I.				he cause of death?
ord	v requir been si should	eted	LEFT MIRITIO	) H100m13	11.5			1	Yes 2 No	3 🗌 Prot	
al Records,		Completed						24a. Was auto perfo 1  Yes	an 24b. psy prmed? 2 No	Were auto prior to co death? 1  Yes	epsy findings available impletion of cause of
Vital		o Be	25. Was case referred to medical examiner?	ospital:	t 2 ER/Outpatier	nt 3□ DOA Othe	26. Place of Death				
of	ing After une	H- 1	1 ☐ Yes → No  27. Manner of Death  1 Natural 5 ☐ Pending 2 ☐ Accident investigation		dence 6 Ott		у)				
Division	al or Attanding ; after death. I Diractor: After d in by the fune	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injur building, etc.	y - At home, farm, str (Specify)		Yes 2 □ No	28f. Location ( City or To	Street and Num wn, State)	ber or Rura	al Route Number,
	To the Hospital or within 24 hours after to the Funeral Dir. completely filled in I	edical C	29a. Certifier 15 Certifying Physical (Check only one) 2 Medical Exami	sician: To the best of ner: On the basis of e and manner state	examination and/or in	h occurred at the tim vestigation, in my o	ne, date and place, pinion, death occurr	and due to the ed at the time,	cause(s) and m date and place,	anner as s , and due to	tated. the cause(s)
	To the vithing To the comp	M	29b. Signature and title of certifier			29c. License	e number		29d. Date signe	ed (Month,	Day, Year)
	6		▶ of	idhi		0269	707		APRIL	6 2	605
	nus		30. Name and address of person who co	mpleted cause of dea	ath (Item 23a) (Type, BiShop	Print) WALSH	Road.	Tumbe	Rland	ine	D 21502
	Sta Registi		31. Date filed (Mohd), Day, Year) APR 0 7 2005	130	's Signature	de				-,	

			For State Registrar	State of Ma	arylan	-	artmen rtificate				ental Hy	/giene	UU	5	14168
	Physici /Medic		1. Decedent's Name (First, Middle	PHILI	P			CR	LAIC		2. Date of D Month	eath Da		Year	3. Time of Death 05:594 M
j	Examin		4a. Facility Name (If not institution  he lehres Ho  5. Social Security Number	oking Hosp	fras	last birthday)	Scr./ If Under	fin 1 Year	Location of	24 Hrs.	8 Date of B		. County	of Death	place (State or Foreign
	Director		170-56-8122 Usual Residence of Decedent	1 <b>⊠</b> M 2□F	36	Yrs.	Months	Days	Hours	Min.	8 Date of B (Month, D NOV • 1	1,19	968		nsylvania
	Marylan a-f show	tor	PA York		10c. Cit	glen								1	1 ☐ Yes 2 No
	3e or 28	I Director	10e. Street and Number 84 Manches	ter St.			10f. Zip	Code 7327					s S . A		ntry?
980	hours after death with the Maryland tural', or Itams 23e or 28e-f show al Examinat must be nutilised at	by Funeral	11. Marital Status 1 X Never Married 2 ☐ Marr 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent B Armed Forces?  1  Yes 2 N If Yes, Give Year or Dates:			Was Deced If Yes, spec	ify Cubar	spanic Ori n, Mexican Specify:	n, Puerto	ecify Yes or N Rican, etc.)	0-		k, White,	can Indian, etc. nite
Maryland 21215-0036	within 72 ene. than "nai	Completed	15. Decedeni (Specify only highes Elementary/Secondary (0-12) 12	s Education t grade completed) College (1-4or 5	+)		dent's Usua kind of wor DO NOT us	rk done d se retired)	tion uring mos	it of worki	ng		ind of Bu		dustry
/land	be filed tal Hyg od othe event,	To Be C	17. Father's Name (First, Middle, Donald J. C								(First, Middle iane			-	
	12 sh h and 7 Is m traum		19a. Informant's Name/Relations Joan D. Marc		•		_				Rock,	-			Code)
Baltimore,	ges t of If it		20a. Method of Disposition 1 ☐ Burial 2 【XCremation 4 ☐ Donation _ 5 ☐ Other (S)		20b. F	Place of Disponentation of Dis	osition (Nan matory or o Me	ne of ther place	9)	Apri 200	1 23,				17404
Baltii	permit. Pa Departmen Important: any injury once.		21. Innature of Funding Sylvice		ı CI	22	2. Name an	d Addres	s of Facili	ty J.J		tenst	ein.	Mort	uary, Inc.
	Pnysician	3 1	23a. Part 1 Priter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	complications that caused only one cause on each line a. DYSRI			er the mod	e of dying	, such as	cardiac c	r respiratory	arrest,			Approximate Interval Between Onset and Death 2 minutes
	/Medical Examiner	Ļ	Sequentially list conditions, if any, leading to immediate	b. Due to (or as Due to (or as Due to (or as	ORGI	AN FA	ILURE								2 oms
V	be executed sician and burial-transit	Examiner	cause. Enter unueriging Cause (Disease or injury that initiated events resulting in death) Last	. SEPSIS	,										3 DAYS
8760,	icate be ex physician a s the burial	icai	researing an addunt East	d. PNEVI											3 MONTHS
O. Box 6	The law requires that the death certificate be executed tae been signed by the attending physician and tage 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 ☐ Feta	aldeath 3□	∃Ectopic pr ∃ Other (sp						23d. Date Mor		ery Day Year
<u>α</u>	quires that n signed b uld be deta	by	Part II. Other significant condition	ns contributing to death be	ut not res	sulting in the u	nderlying c	ause give	n in Part I	l.					ne cause of death?
Records,		Completed									24a. Wa auto pen 1 ☐ Yes	opsy formed?	p	Vere autorior to coleath?	psy findings available inpletion of cause of
Vital	siclan: certific rector,	o Be C	25. Was case referred to medical examiner?	Hospital:	-+ 2	I ED/Outration		Othe			(Check only	one)		(0	
of	fter	H-1	27. Manner of Death  1 Natural 5 Pendin 2 Accident investig			ER/Outpatier 28b. Time o Injury		8c. Injury Work	4 🗀 191	1	me 5 Res 28d. Describe				у)
Division	Dir	Certification:	3 □ Suicide 6 □ Could determ		ury - At h c. (Specia	ome, farm, sti fy)	reet, factory	, office				(Street ar own, State		er or Rura	al Route Number,
	To the Hospital within 24 hours a To the Funeral I completely filled	edicai (	29a. Certifier 1 Certifyin (Check only one)	g Physicien: To the best of Examiner: On the basis of and manner sta	examina	owledge, deat ation and/or in	h occurred vestigation	at the tim , in my op	e, date ar inion, dea	nd place, a	and due to the ed at the time	e cause(s e, date an	) and ma d place, a	nner as s ind due to	tated. the cause(s)
	To the I within 2 To the I complet	Me	29b. Signature and title of certifie				290	. License		200			-		Day, Year)
			30. Name and address of person	0	eath (Iter	n 23a) (Type.	Print)	KE	S - C			MERI	16	1, 4	
	8		DA. KIBANAN DEANGE	is Juhns Horki	ns Ho	SPITAL (	,	LTH WO	uft s	TLEET	BALTIH	see H	IARYL	Lin	21287
	Sta Regist		31. Date filed (Month, Day, Year)  APR 2 6	2005 32 tegistra	ar's Signa اواس	ture	all)								

			partment of Health and N e <i>rtificate of Death</i>	Mental Hygien	1000 14100
Physi				2. Date of Death Month	Day Year 3. Time of Death
/Med Exam			4b. City, Town, or Location of Death	4	Ic. County of Death
Funera Directo		5. Social Security Number  6. Sex  1 ☑ M 2 □ F  7. Age (In yrs. last birthd  Yrs.  7. Age (In yrs. last birthd)	Months Days Hours Min	8. Date of Birth (Month, Day, Yea	9 Birtholace (State or Foreign
Maryland 1-1 show	tor	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town of MD Prince George's Capito	Location  1 Heights		10d. Inside City Limits 11 Yes 2 □ No
with the	Director	10e. Street and Number  12 Whist Place	10f. Zip Code 20743		Citizen of What Country?
IOTE, Maryland 21215-UU36 ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-1 show or other traumatic event, the Medical Executar investigation	by Funeral	11. Marital Status 11. Marital Status 1 □ Never Married 2 ☑ Married 1 □ Never Married 2 ☑ Married 1 □ ☑ Yes 2 □ No Army	3. Was Decedent of Hispanic Origin? (Sr If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☑ No Specify:		U.S.A.  14. Race - American Indian, Black, White, etc.  Specify: Black
21215-0036 d within 72 hours aft giene. er than "natural", or , the Madical Ext. of	Completed by	15. Decedent's Education (Specify only highest grade completed) (G	cedent's Usual Occupation ive kind of work done during most of work b. DO NOT use retired) intenance	king	Kind of Business/Industry  Private
Maryland 2121 d 2 should be filed within th and Mental Hygiene. t7 is marked other than " traumatic event, Ite Ma-	To Be Co	17. Father's Name (First, Middle, Last)	18. Mother's Nam	ne (First, Middle, Maide r Latson	
Mary nd 2 sho lith and h 27 is ma		19a. Informant's Name/Relationship (Type, Print) 19b. M	ailing Address <i>(Street and Number or Ru.</i> Whist Place Capito		
Saltimore, sermit. Pages 1 ar Department of Hea mportant: if them nny injury or otha	F	1 XBurial 2 Cremation 3 Removal from State cemetery,	sposition (Name of rematory or other place) d Veteran's 4/15/		Location - City or Town, State
Baltimore, IViting permit. Pages 1 and 2 Department of Health a Important: if item 27 is any injury or other trains.	OUCB.	21. Signature of Europe Service Licensee	22. Name and Address of Facility J. 7474 Landover Road	B. Jenkin	s Funeral Home
Physicia /Medica	_	23a. Part1. Enter the disease, or como lications that caused the death. Do not shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):		or respiratory arrest,	Approximate Interval Between Onset and Death
ficate be executed Executed Probability of physician and sthe burial-transity	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last  b			
the death certiff y the attending ched for use as	Physician/Medi		3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of delivery Month Day Year
v requires that been signed by should be deta	þ	Part II. Other significant conditions continuuting to death out not resulting in the	e underlying cause given in Part I.		o use contribute to the cause of death?  2 No 3 Probably 4 Onknown
	Completed			24a. Was an autopsy performed?	
on or vital riding Physician: The h.  After this certificate funeral director, pag	tion: To Be	examiner? 1  Yes 2 No Hospital: 1 Inpatient 2 EP/Outpa	tient 3 DOA Other. 4 Nursing H	th (Check only one) ome 5 Pesidence 28d. Describe how in	
DIVISION  To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the fune	Certification:	3 Suicide 6 Could not be determined 4 Homicide determined building, etc. (Specify)		28f. Location (Street City or Town, Sta	and Number or Rural Route Number, ate)
the Hospital or hin 24 hours afte the Funeral Dir	Medical C		eath occurred at the time, date and place, investigation, in my opinion, death occur	and due to the cause rred at the time, date a	(s) and manner as stated. ind place, and due to the cause(s)
To the within To the compl	Me		29c. License number		Date signed (Month, Day, Year)
2 (2)		30. Name and address of person who completed cause of death (Item 23a) (Ty  SHUH DV SV ESTER 300/  31. Date filed (Month Day Year)  22. Registrate Signature	pe, Print)	Ch	1 here / 1613
Regi	State	A D D : 4 O COOF	NUS FUTEN SINE	- CIEVE	114 may con

		1 - For State Registrar	State of Maryland		artment rtificate			d Mental H	lygiene Reg. No	20115	14170
Physici /Medic		1. Decedent's Name (First, Middle, Las  Daisy Mae Da	vis					2. Date of Month	Death Da	Year Year	3. Time of Death
Examin	er	4a. Facility Name (If not institution, give  Laure Reg  5. Social Security Number 6. Se	const togi	tal st hirthday)		- an	Location of De		1		George's
Funeral Director		266-45-4358 Usual Residence of Decedent	□M 2□x 43	Yrs.	Months	Days		in. (Month,	Day, Year)	961 G	thplace (State or Foreign puntry) eorgia
he Marylar 8e-f show ottilied at	Director	· · · · · · · · · · · · · · · · · · ·	George's	Town or Lo	В		sville				10d. Inside City Limits 1 X Yes 2 ☐ No
h with t		10e. Street and Number 7904 Allow	ay Lane		10f. Zip (	Code	20705		10g. Ci	tizen of What Co United	States
be filed within 72 hours after death with the Maryland tal Hyglene. d other than "neturel", or items 23a or 23e-f show event. The Medical Exam har must be motified at	by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 ★ Yes 2 □ No If Yes, Give Year or Dates:		Was Decede		panic Origin? , Mexican, Pu Specify:	(Specify Yes or ento Rican, etc.)	No-	14. Race - Ame Black, Whit Specify:	
ithin 72 ho ne. han "netur Medical"	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)		(Give	DO NOT use	done du retired)	tion uring most of v	working	16b. K	Kind of Business/	Industry
	Be	17. Father's Name (First, Middle, Last)  Sylvester	7   Tavlor		Nur		18. Mother's h	Name (First, Midd		Privat Sumame) Smith	te
nd 2 should be tith and Menta 27 is marked r traumatic ev	To	19a. Informant's Name/Relationship (7	ype, Print)					Rural Route Nun	nber, City o	or Town, State, 2	Zip Code)
t. Pages 1 artment of Heartant: if item		Robert Davis —  20a. Method of Disposition  1 Burial 2 X Cremation 3   4 Conation 5 Other (Specify	Removal from State All	netery, crei		of erplace rema	tory 4	/19/2005	20c. L	083 ocation - City or Opa Loc!	ka, FL
Depar Impor any ir		21. Signature of Funeral Service Licens	Tengant TI	22	2. Name and 4001		- Contract - Contract	Stewart N.E.		eral Hor ., DC 20	77.50
Certificate be executed / Medical Examiner / Medica	ilcai Examiner	23a. Part . Enter the disease, or comp shoot, it heart failure. List only of immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, any leading the shoot of the cause. Enter Underlying Cause (Disease or injury that intitated events resulting in death) Last	b. Due to (or as a conseque  C	ence of): etes	2		ity		arrest,		Approximate Interval Between Onset and Death
certific	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	23c. If yes, outcome of pregnand 1□Live birth 2□Fetal of 4□Pregnant at time of dea 9□Unknown	death 3□	Ectopic pred Other (spec					23d. Date of deli Month	ivery Day Year
faw requires that the death as been signed by the atter 2 should be detached for u	by	Part II. Other significant conditions co	ontributing to death but not result	ting in the u	nderlying cau	ise giver	n in Part I.		tobacco		the cause of death?
The ate h page	Completed							рө	as an topsy formed?	prior to death?	topsy findings available completion of cause of
icien: sertific ector,	Be	25. Was case referred to medical examiner?	Hospital:					eath (Check only			
ding Phys th. After this funeral di	ation; To	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	1 ☐ Inpatient 2 ☐ E	R/Outpatier 28b. Time of Injury		: Injury :	at	Home 5 ☐ Re 28d. Describ			city)
itei or Atten rs after deal rei Director: led in by the	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hom building, etc. (Specify)	ne, farm, str	eet, factory,	office		28f. Location City or 7	(Street an own, State	nd Number or Ru a)	ral Route Number,
To the Hospitel or within 24 hours af To the Funerel D completely filled in	edical	29a. Certifier 1 ☐ Certifying Phy (Check only one) 2 ☐ Medical Exam	rsician: To the best of my knowliner: On the basis of examination and manner stated.	ledge, deat! on and/or in	occurred at vestigation, in	the time my opi	, date and pla nion, death oc	ice, and due to th curred at the tim	e cause(s) e, date and	) and manner as d place, and due	stated. to the cause(s)
To the within 2 To the complet	Σ	29b. Signature and title of certifier  Achaely	phost so			License		7		te signed (Month	
(2)		30. Name and address of person who of SALVADON SALVS		23a) (Type,	Print)  Dr	ومه اه	Che	venly	MA	1. In	d
Sta Registr		31. Date filed (Month, Day, Year)  APR 1 3 2005	2. Registrar's Signatu	-	A.	,		11		1	

			For State Registrar	State of Maryland		artment of F			giene	) 5	14171
			Decedent's Name (First, Middle, Last)					2. Date of Dea	ath		3. Time of Death
	Physicia /Medic		RAYMOND HINK	LE DUCKWORT	Н			MARCH	Day 31, 20	Year 105	15:20 M
	Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, o	r Location of Deat			ty of Death	15.20
	en ein Fr		MEMORIAL HOSPITAL			CUMBERI			ALLE	GANY	
	Funeral		5. Social Security Number 6. Sex	IM 2DE	**	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	(Month, Da	h y, Year)	9. Birth	place (State or Foreign ntry)
	Director	-	236-42-0166 Usual Residence of Decedent	78	Yrs.			JULY 18	3,1926		VIRGINIA
	land ow		10a. State 10b. County	10c. City, 7	own or Lo	cation					10d. Inside City Limits
	Mary I sh	ţ	WV HAMPSHI	RE GRE	EN S	PRING					1 ☐ Yes 2X No
	or 28g	irec	10e. Street and Number			10f. Zip Code			10g. Citizen of	What Cou	ntry?
	23£ (	by Funeral Director	HC 86, BOX 33			26722	2		U.S.	Α.	
	tems tems	ne	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13.	Was Decedent of H f Yes, specify Cuba	lispanic O <i>r</i> igin? (S an, Mexican, Puer	pecify Yes or No to Rican, etc.)		ace - Ameri ack, White	
36	s afte	y Fi	1 ☐ Never Married 2 X Married 3 ☐ Widowed 4 ☐ Divorced	1 □ Yes <b>XX</b> No If Yes, Give		1 ☐ Yes XXNo	Specify:		Spec	i6	ITE
21215-0036	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or ttems 23s or 28s-f show ont, the Medical Examiliter must be multified at		15. Decedent's Edu	Year or Dates:	I6a Dece	dent's Usual Occup	ation		16b. Kind of		
15	n "na	Completed	(Specify only highest grade	completed)	(Give	kind of work done DO NOT use retired	during most of wor	rking	TOD. INITIA OF	Dusinessyn	idustry
212	d with	E	Elementary/Secondary (0-12)	College (1-4or 5+)	LA	BORER			KOPP	ERS C	0.
	be file ital Hy id othe avent,	Bec	17. Father's Name (First, Middle, Last)				18. Mother's Nar	ne (First, Middle,	Maiden Suma	ıme)	
yla	should bund Ment marked umatic a	ပ္	HARRY E. DUCKWO	ORTH			BERTHA	INEZ	HINKLE		
Maryland	0 0 0		19a. Informant's Name/Relationship (Ty			ng Address (Street				n, State, Zij	c Code)
	l and Health m 27 har tr		PAMELA K. KIMBLE  20a. Method of Disposition			D. BOX 37 sition (Name of	3, ROMNE	Y, WV Z	26757		
Baltimore,	if ite		1⊠ Burial 2 ☐ Cremation 3 ☐ F	lemoval from State cem	etery, crei	natory or other plac	· 1		20c. Location		
量	it. Partmer	1	<ul><li>4 □ Donation 5 □ Other (Specify)</li><li>21. Signature of Funeral Service Licens</li></ul>		-	LEN CEMET		13/2005	GREE	n SPR	ING, WV
Ba	permit. Pages 1 and Department of Health Importent: If item 27 any injury or other to		1 Day - 1 D	lochun.	-	Name and Addre UPCHURCH	I FUNERAL	HOME,	INC.		
	4		23a. Part1. Enter the disease, or compl	ications that caused the death.	Do not ent		1260, F			2671	Approximate
	Physician		shock, or heart failure. List only or Immediate Cause (Final	_		Ç	Δ i	1			Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	Due to (or as a consequer		war /	700101	ent			1 week
г	Examiner				,						
	P =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequer	nce of):						
	ocutec nd transi	Examiner	Cause (Disease or injury that initiated events								
Ő,	ate be executed physician and the burial-transit		resulting in death) Last	Due to (or as a consequer	nce of):						
8760,	death certilicate be executed e attending physician and od for use as the buriat-transit	dicai		d							
9 ×	eath certific attending pl	/Med	IF FEMALE:	3c. If yes, outcome of pregnanc	v						
Вох	atten for us	ian	in the past 12 months?	1 Live birth 2 Fetal de	ath 3[	Ectopic pregnancy Other (specify)	/			ate of deliv Ionth	ery Day Year
P.O.	y the	Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown	36	_ опы ( <i>specify</i> ) _					
	The law requires that the de tie has been signed by the bage 2 should be detached		Part II. Other significant conditions con	ntributing to death but not resulti	ng in the u	nderlying cause giv	en in Part I.	23e. Did to	obacco use co	ntribute to t	he cause of death?
rds	quires n sign	ed by	Diabetes Me	Mitus				101	Yes 2□No	3 ☐ Prol	babiy 4 📆 Unknown
Records,	s bee	olete	Caronary Arte	ry Disease				24a. Was	an 24b	. Were auto	ppsy findings available
	The fav	Completed						autop perfo 1 ☐ Yes	rmed?	death?	mpletion of cause of 2□ No
Vital		0	25. Was case referred to medical				26. Place of Dea	ath (Check only o		1 1 1 1 1 1 1 1 1 1 1	2 140
<b>&gt;</b>	99 (6.3	To B	examiner? 1 ☐ Yes 2 🛣 No	lospital: 1 XI Inpatient 2 ☐ EF	VOutpatie	nt 3 DOA Oth	er: 4 🗆 Nursing H	lome 5 ☐ Resid	dence 6 🗀 O	ther (Speci	fy)
n of	ttending Phy death. stor: After this the funeral c		27. Manner of Death 1 ■ Natural 5 □ Pending	28a. Date of Injury 28 (Month, Day Year) 28	Bb. Time o	f 28c. Injur Wor	y at k?	28d. Describe h	now injury occu	ırred	
sio	Attending r death. actor: After	cati	2 Accident investigation 3 Suicide 6 Could not be			M 1 □	Yes 2 □ No				
Division	or A fter Dirac in by	Certification:	4 Homicide determined	28e. Place of Injury - At home building, etc. (Specify)	e, farm, st	eet, factory, office		28f. Location (S City or Tox		nber or Run	al Route Number,
	To the Hospitel or At within 24 hours after of To the Funerel Diracl completely filled in by	Ce	29a, Certifier 1 ★ Certifying Phy	Picions To the heat of multiple 1	ndae it	<b>5 </b>	det 1 1				
	To the Hospitel within 24 hours a To the Funeral Completely filled	edical		sicien: To the best of my knowled ner: On the basis of examination and manner stated.	n and/or in	vestigation, in my c	ne, date and place printon, death occu	red at the time,	cause(s) and n date and place	nanner as s , and due t	o the cause(s)
	o the vithin o the	Med	29b. Signature and title prentitier	and manner added.		29c. Licens	e number		29d. Date sign	ed (Month,	Day, Year)
	7		· What	~~~		D 3 3	2200		Am	0 1	2005
•	1		30. Name and address of person who co	ompleted cause of death (Item 2	3a) (Type.		3280		V John		<u> </u>
-	MAS		GUPTA, SUNIL K	M.D., 625 KENT	AVE	NUE, SUIT	E 101. C	UMBERLAN	ID, MD	21502	
			31. Date filed (Month, Day, Year) APR 0 4 2	32. Registrar's Signatur	0,0	1 4	,				
	Sta Registr		ADD A A o	DOM: No Section	11.00	Carlo all. B.					

	T- State of Maryland Registrar	I / Department of Health and Mental Hy Certificate of Death	2000 14172
9	Decedent's Name (First, Middle, Last)	2. Date of D	
Physician /Medical	James H. Deboard	Month Apri	1 17, 2005 1:11 AM
Examiner	4a. Facility Name (If not institution, give street and number) Hospice of Baltimore at Gilchrist Center	4b. City, Town, or Location of Death  Towson	4c. County of Death Baltimore
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. la:	st birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Bi (Month, D Yrs. Annual Page 14 Hrs. 15 Annual Page 1	Pay, Year) Country)
and	Usual Residence of Decedent           10a. State         10b. County         10c. City.	Town or Location	10d. Inside City Limits
Maryl f sho		ite Hall	1 ☐ Yes 2 🛣 No
d 21215-0036 d 21215-0036 lifed within 72 hours after death with the Maryland Hygiene. then "neturel", or liems 23e or 28e-f show with the Modest Examinet must be notified at and, the Modest Examinet must be notified at a Completed by Funeral Director	10e. Street and Number 2808 McComas Road	10f. Zip Code 21161	10g. Citizen of What Country? U.S.A.
1, 2005 16 16 atter death wi or Items 23e. mirrer must b.	11. Marital Status  12. Was Decedent Ever in U.S Armed Forces?  1 □ Never Married 2 ☒ Married 1 ☒ Yes 2 □ No	If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	
5-0036 72 hours atter of the distal Examine eted by Fur	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates: Kore	a 1□Yes 2₺ No Specify:	Specify: White
15-( 15-( 0.72 h	15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
April  21215-00  64 within 72 hou ygiene. her then "neture it, the wides! Completed	Elementary/Secondary (0-12) College (1-4or 5+)	Lineman	Communications
Baltimore, Maryland 21 Baltimore, Maryland 21 permit Pages 1, and 2 should be filed w Department of Health and Mental hygie Importent: If them 27 is marked other tany injury or other treumetic event. In once.  To Be Coi	17. Father's Name (First, Middle, Last)  Robert Calvin Deboard	18. Mother's Name (First, Middle Emma Theora	
lary 2 shou and M is mar seumet	19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Num	
e, N 1-and 1 Health 9m 27 ther tr	Dorothy Deboard  20a. Method of Disposition 20b. Pla	2808 McComas Rd., White	Hall, MD 21161  20c. Location - City or Town, State
Baltimore, permit Pages 1,at mportant if item morpital: if item any injury or other page.	1 XBurial 2 Cremation 3 Removal from State Velocity Met	rnon United April 22, thodist Cemetery 2005	White Hall, MD
Baltimo	21 Square Funeral Service License e	22. Name and Address of Facility J.J. Har 24 Second St., New	
Physician	23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition	. Do not enter the mode of dying, such as cardiac or respiratory	Interval Between Onset and Death
/Medical Examiner	resulting in death)  Due to (or as a consequence)		menths
L Si Se L	Sequentially list conditions, if any, Lading to immediate cause. Enter Underlying Cause (Disease or injury	ence all):	
68760, <li>flicate be executed physicien and is the burial-transit edical Examiner edical Examiner</li>	that initiated events resulting in death) Last C. Due to (or as a consequence)	ence of):	
68760, ifficate be experience of the burial set the burial edical Experience of the burial edical edica	d		
Division of Vital Records, P.O. Box 6  To the Hospitel or Attending Physicien: The law requires that the death certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as Medical Certification: To Be Completed by Physician/Medical Certification:	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome of pregnant 1 □ Live birth 2 □ Fetal of 4 □ Pregnant at time of decent in the part of the pregnant at time of decent in the part of the pregnant at time of decent in the part of the pregnant at time of decent in the part of the pregnant at time of decent in the part of the part	death 3 Ectopic pregnancy	23d. Date of delivery Month Day Year
ds, P. ires that the signed by the detail	Faith, Other significant conditions contributing to death but not result	\	tobacco use contribute to the cause of death?  Yes 2 \( \subseteq \) No 3 \( \subseteq \) Probably 4 \( \subseteq \) Unknown
I Record  The law require tale has been s page 2 should		24a. Wa	as an 24b. Were autopsy findings available
I Re la The la ate has page 2		per	opsy prior to completion of cause of death? 2 ☑ No 1 ☐ Yes 2 ☑ No
Vita icien: certific ector,	25. Was case referred to medical examiner?	26. Place of Death (Check only	
of N Physi or this corrupts or this corrupts of the corrupt of the corrupts of the corrupt of the corrupts of	To res 2/2/No To inpatient 2016	28b. Time of 28c. Injury at 28d. Describe	sidence 6 Sther (Specify) 125 PCC e how injury occurred
sion anding ath. or: Afte	1 □ Natural 5 □ Pending (Month, Day Year) 2 □ Accident investigation	Injury Work?  M 1 ☐ Yes 2 ☐ No	
Division of Vital Records, tel or Attending Physicien: The law requires the staffer death.  el Director: After this certificate has been signed in by the funeral director, page 2 should be Certification: To Be Completed by	3 Suicide 4 Homicide  6 Could not be determined  28e. Place of Injury - At hor building, etc. (Specify)	me, farm, street, factory, office 28f. Location City or T	(Street and Number or Rural Route Number, own, State)
he Hospit in 24 hours the Funere pletely fille	29a. Certifier (Check only one)  1 ▶ Certifying Physician: To the best of my know one)  1 ▶ Medical Examiner: On the basis of examination and manner stated.	wledge, death occurred at the time, date and place, and due to the ion and/or investigation, in my opinion, death occurred at the time	
To the within To the comp	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year) APML 17 2.007
4	30. Name and address of person who completed cause of death (Item  Amor Charles M 660)	1- Charles Sr Bultimere 1	NO 21204
State Registrar	31. Date filed (Month, Day, Year)  APR 2 6 2005		1

Joshua Edwards 05-02750 crn

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene O O C

hysician		. Decedent's Name (First, A		Lamar	Edward	ds				2. Date of De Month	eath	/ 2X	005	3. Time o	
Medical xaminer	L	a. Facility Name (If not insti					4b. City,	Town, or	Location of Dea			County of		5:00	Ам
		74 E. Broadw	ay					el Ai				Harf			
neral ector		. Social Security Number 231–51–8439		M 2□F		6 Yrs.	If Under Months	r 1 Year Days	If Under 24 Hrs Hours Min	. (Month, D	rth a <i>y, Year)</i> 0, 19	988	Birthp Coun Vir	lace (State of try) ginia	or Foreign
ed at	-	Usual Residence of Deceder 0a. State 10b. Co			10c. C	ity, Town or Lo	cation						1	0d. Inside C	ity Limits
or other traumatic event, the Nedical Examinar intuities instituted at or other traumatic event, the Nedical Examinar intuitied at To Be Completed by Funeral Director	I	Maryland	Harfo	rd				Bel	Air					1 ☐ Yes	2 <b>∑</b> No
be natified Director	1	0e. Street and Number	a dr				10f. Zip		24.04.4		10g. Cit	izen of Wh		try?	
dintimati Funeral	+	74 E. Bro		2. Was Dec	edent Ever in	U.S. 13. V	Was Dece		21014	Specify Yes or N	0-	14. Race -	SA Americ	an fndian.	
any injury or other traumatic event, the Medical Examination once.  To Be Completed by Funer	1	1 X Never Married 2 ☐ 3 ☐ Widowed 4 ☐ Divo		Armed For 1 ☐ Yes If Yes, Giv Year or D	2∭No ve		fYes, spe 1 ☐ Yes		Specify:	Specify Yes or N to Rican, etc.)		Black, Specify:	White, B1	etc. .ack	
eted	F	15. Dec (Specify only h	edent's Educi	ation completed)		16a. Deced	kind of wo	ork done d	lurina most of wo	nrking	16b. K	ind of Busi	ness/Ind	dustry	
it, the Medical I		Elementary/Secondary (0-	12)	College (	1-4or 5+)	life. I	οο νοτ ũ Co	ise retired, ok	)		Fast	Foo	i Re	staur	ant
evant, 1 Be Co		7. Father's Name (First, Mic	idie, Last)						18. Mother's Na	me (First, Middle	-			Deade	
To E	-	Ralph Bunc		_	· · ·					a Mays					
traum		19a. Informant's Name/Rela								ural Route Numb				Code)	
other	Rebecca Mays / mother 74 E. Broadway Bel Air Maryland 21014  20a. Method of Disposition  1 X Burial 2 Cremation 3 Removal from State  20b. Place of Disposition (Name of cemetery, crematory or other place)												wn, State		
ry or		1 X Burial 2 ☐ Crema 1 4 ☐ Donation 5 ☐ Oth		moval from	State Ha		-		Grds. 4/	23/05	Ak	erde	en,	Maryla	and
any inju	Ī	21. Signature of Funeral Ser	vice License	; ;***		22	Name ar Lise 552	a Sco	s of Facility Ott Fune	ral Home	e, P.	A.	- M	- D 210'	7 <u>0</u>
		23a. Part1. Enter the diseas shock, or heart failure.	e, or complic List only one	ations that o	caused the dea	ath. Do not ent	er the mod	de of dying	g, such as cardia	c or respiratory	arrest,	Grace	-, I'I	Approximation Interval Bel	te
ian		Immediate Cause (Final disease or condition	a	Seizu	re dis	order								Onset and	Death
ical ner		resulting in death)			(or as a conse										
e e		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b.	Due to	(or as a conse	quence of):							-		
Examiner		hat initiated events	c.												
dical Examir	1	resulting in death) Last		Due to	(or as a conse	quence of):							H		
edical			d.		·								-		
		F FEMALE: 23b. Was decedent pregnar	t 23		tcome of pregi		]C -+i					23d. Date of	of delive	ry	
be detached for use by Physician/M		in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown			ointh 2 □ Fe nant at time of own		Ectopic pi Other (sp					Month	1	Day	Year
be detached by Physic	F	Part II. Other significant co	nditions cont	ributing to d	eath but not re	sulting in the u	nderlying o	cause give	in in Part I.	23e. Did	tobacco i	ise contrib	ute to th	e cause of o	death?
										1 🗆	Yes 2	☑ No 3	☐ Prob	ably 4 🗍	Unknown
Completed										24a. Was		24b. We	re autor	osy findings	available
Con										perf	ormed? 2 □ No	dea	ath?	2□ No	
Be	1	25. Was case referred to me examiner?		spital:				Othe		ath (Check only		enary.		Family Long	
tuneral director, page		LXYes 2 No 27. Manner of Death		1 1 1	Inpatient 2{ of Injury th, Day Year)	28b. Time of	-	28c. Injury	at at	Home 5 Res				at sc	ene
atio		1 Natural 5 Pe	ending vestigation	(Mon	th, Day Year)	Injury	м	Work	? (es 2 □ No						
ed in by the tunera		3 Suicide 6 C 4 Homicide de	ould not be termined	28e. Place build	of Injury - At ing, etc. (Spec	home, farm, str sify)	eet, factor	y, office		28f. Location City or To	(Street an own, State	d Number )	or Rura	Route Nun	iber,
completely tilled in by the		29a. Certifier 1 Cer (Check only 2 Med one)	tifying Physi lical Exemin	er: On the b	best of my kr asis of examir ner stated.	nowledge, death nation and/or inv	occurred vestigation	at the tim	e, date and place inion, death occ	e, and due to the urred at the time	cause(s) , date and	and mann place, and	er as st	ated. the cause(s	;)
completely tilled in by the		29b. Signature and title of ce	rtifier	1.1	1			c. License	number			te signed (i			
		Das	ha's	The	enh	eg M	0	OCME			Apr:	il 20	, 20	)05	
	1	30. Name and address of pe	rson who con	pleted caus	se of death (Ite	эт 23а) (Туре,	Print)								
		lasha	1 /0-	VERN	bera	M.D.		111 1	Penn Ctr	eet Ba	1+1-	120 1	Via	1054	2120

			For State Registrar		State o	f Marylan	d / Depa		of H	lealth ar				005	monumany estimates	74
	Dhuaisia		1. Decedent's Nam	e (First, Middle,	Last)							Date of Deat	h Day	Year	3. Time of	Death
	Physicia /Medic:	_	HILDA	L	М.	EVANS	3					oril '	12,	2005	12:2	5 P <sup>M</sup>
	Examine		4a. Facility Name (	If not institution,	give street and nu	mber)		4b. City,	Town, or	Location of	Death		4c. C	County of Death	1	
			BERLIN N	URSING	& REHAB.	CENTER			ERLI					WORCEST	CER	
	Funeral		5. Social Security N		1. Sex 1	7. Age (In yrs. I		If Under Months	1 Year Days	If Under 24 Hours	Min.	Date of Birth (Month, Day,	Year)	9. Birth	nplace (State o	r Foreign
	Director		222-50-1		- X	74	Yrs.				AP	RIL 29	, 19	930 DEL	AWARE	
	and		Usual Residence of 10a. State	10b. County		10c. City	y, Town or Lo	ocation							10d. Inside Ci	ty Limits
	Manyl f ehc	ō.	DT 4774 D.D.	auga T	37			TITE							1 🗌 Yes	-
	28a-	P. C.	LLAWARE 10e. Street and Nu	SUSSE	Χ		SELBYV	10f. Zip	Code			10	Da. Citiza	en of What Co		
	With 39 or	٥	DD E						199	75			US		,	
	death me 2	era	11. Marital Status	BOX 45	12. Was Dec	edent Ever in U.	S. 13.	Was Deced		ispanic Origi In, Mexican,	in? (Specify	Yes or No-		4. Race - Amer		
9	after or ite	ᆵ	1 Never Marr	ried 2[X] Marrie	d 1 ☐ Yes	2 No No	į.				Puerto Rica	in, etc.)		Black, White		
M. 21215-0036	be filed within 72 hours after death with the Maryland ital Hygiene. Id other than "netural", or iteme 23e or 28a-f show event, it e Madical Examiner man be notified at	à	ELAWARE  10e. Street and Nur  RR 5,  11. Marital Status  1 Never Marr  3 Widowed  (Special Communication of the Co	4 Divorced	If Yes, Gir Year or D	VB		1 Yes 2	X No	Specify:			9	Specify: W	HITE	
5-0	72 h	etec	(Spec	15. Decedent's	Education grade completed)		16a. Dece	dent's Usua	Occupa	ation during most o	of workina		16b. Kin	d of Business/I	ndustry	
. 5	within 600.	npi	Elementary/Seco	<del></del>	College (		lite.	DO NOT us	e retired	during most o	······ <b>y</b>					
	filed w Hygier ether th	S	12_	· · · · · · · · · · · · · · · · · · ·			HOME	MAKER	1					N HOME		
da	be fi	w										rst, Middle, N		Sumame)		
il.	should be filed withir nd Mental Hygiene. marked other then maric event, It e M.	ို		AN H. LO	· · · · · · · · · · · · · · · · · · ·							HASTIN				
Hilda Maryland	an an		19a. Informant's N										-	Town, State, Z		
	s 1 and of Heelth item 27 other to		H. VICTOR		JR./HUS		KK 5			SELB	Y V LLLi Date			E 19975		
vans timore	00		1 🔀 Burial 2	☐Cremation 3	B Removal from		emetery, cre	matory or of	her plac	1		100	200. LOC	ation - City or 1	rown, State	
Evans, altimore,				5 Other (Spe		BIS	HOPVII				4/15/0	05 _	BISH	OPVILL	E, MARY	LAND
Bal	permit. Departr Importe any inju		21. Signature	neral Service Li	CORSON S	A-s		2. Name and						D.	77 AVIA D.F.	1007
-	20200		220 Post Enter	uly n	omplications that of	2								LLE, DI		
			shock, or hea	art failure. List o	nly one cause on	each line.	n. Do not en	ter the mode	or dyln	1	- /		est,		Approximat Interval Bet Onset and I	ween
	Physician / /Medical		Immediate Cause disease or condition resulting in death)	on	_a	rel II	rege	rec	rel		clar				Cens	3
	Examiner		<b>3</b>	1	Due	or as a conseq	uego of):	rc (	Rock	150,000	20.11	r De	2		4	_
		-	Sequentially list co	onditions,	b. /VV C	(or as a conseq	THE CONTRACTOR			u over	aceni	1 100.	XU	ع و	veu	>
-	ted nsit	Examiner	Sequentially list co if any, leading to in cause. Enter Unde Cause (Disease or that initiated event	ertying r injury	(	(5. 45 2 55.1554	201100 017.									
	siclan and burial-transit	xar	that initiated events resulting in death)	s Last	c	(or as a conseq	uence of):									
8760,	ate be ex nysician he buria	icai														
687	ficate physics the	edic			o											
Вох	leath certifica attending ph I for use as t	Physician/Med	IF FEMALE: 23b. Was deceder	at oregonant		tcome of pregna							23	3d. Date of deli	verv	
ĕ	death atte	ciai	in the past 12	months?		oirth 2 Feta nant at time of d		Ectopic pro Other (spe						Month		Year
P.O.	the cachecachec	hys	9 Unknown		9□ Unkn	iown										
	Attending Physicien: The law requires that the death certificate be executed rideath. rideath. ector: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit	by P	Part II. Dther signi	ficant condition	s contributing to d	leath but not res	ulting in the u	underlying ca	ause give	en in Part I.		23e. Did tob	acco us	e contribute to	the cause of d	eath?
ş	quire n sig uld bi											1 🗀 Ye	s 2 🗆	No 3□Pro	obably 4	Inknown
ပ္ပ	tw require s been sig	iete										24a. Wasa	n	24b. Were au	topsy findings	available
æ	The lav ate has page 2	Completed										autops	ned?	prior to c death?	completion of c	ause of
ta	iclen: Th certificate rector, pag	a	25. Was case refe	rred to medical						26 Place (	of Death (C	1 ☐ Yes 2	No	1 🗌 Yes	2 No	
<u> </u>	yeiclen: is certific director,	To B	examiner?	ZNo	Hospital:	Inpatient 2	ER/Outpatie	nt 3 DO	A Oth	or N				Other (Spec	ufu)	
Division of Vital Records,	ding Phyen. h. After this funeral di		27. Manner of Lea		28a. Date	of Injury oth, Day Year)	28b. Time o		8c. Injun	y at		Describe ho			,/	
į	ath. r: Aft	atlo	1 Accident	5 🗌 Pending investiga		in, Day 16ai/	IIIquiy	М		x? Yes 2 □ N	lo					
Vis Vis	Atte	tific	3 Suicide 4 Homicide	6 Could no determin	288. Place	e of Injury - At ho ling, etc. (Specif	ome, farm, st	treet, factory	, office		28f.	Location (St. City or Town		Number or Ru	ral Route Num	ber,
Ö	s afte	Certifications		/	Dana	ing, oto. (opoon	,,					ony or roun	, olalo)			
	To the Hospitel or Attendia within 24 hours after death. To the Funerel Director: A completely filled in by the fur		29a. Certifier (Check only	Certifying	Physician: To the xaminer: On the b	e best of my kno	wiedge, dea	th occurred	at the tim	ne, date and	place, and	due to the ca	use(s) a	and manner as	stated.	
	the H hin 24 the F nplete	Medical	one)		and man	ner stated.		ivestigation,	in my o	pinion, death	1 occurred a					)
	With To t	Σ	29b. Signature and	Mile of certifier				290	License	e number	60	2:	9d. Date	signed (Month	n, Day, Year)	~
T	OB	/	1/1/	ONE	relel	rin	1	1	0	101	6	0	4/	10/5	10	>
	28		30 Name and add	lress of person w	no completed cau	se of death (Item	п 23а) (Туре	, Print)	12	09	Cec	2 star	1	Feglie	No.	1.1
_	0)		1 20000	and No	10100	reelia	100	4	FC	رودس	the 4	ly lee	el,	De	1970	14
	Sta		31. Date filed (Mor			Registrar's Signa	ture									,
	Registr	ar		APR 14	2005	Value .	H. I	Tours.	,							

			For State Registrar		State	of Mai	ryland	_			ealth a Death		ental Hy	giene Reg. No	. U U	5	est Pra	75
	1. Decedent's Name (First, Middle, Last)														te of Death 3. Tir			Death
	Physicia		Bernard A. Ethier						Month April					Day Year 6:55			A <sup>M</sup>	
)	/Medic Examin		4a. Facility Name (If not institution, give street and number)						4b. City,	Town, or	Location	of Death	119122		. County		0.33	-11
	_xamii.		Shady Grove Adventist Hospital						Rocl	cvil]	e			M	lontg	omer	v	
	Funeral		5. Social Security Number	6. Sex	(		(In yrs. last	t birthday)	If Unde	r 1 Year	If Under		8. Date of Bir	th		9. Birthp	lace (State o	or Foreign
	Director		017-10-2154	1 🗵	M 2□F		88	Yrs.	Months	Days	Hours	Min.	(Month, Da 06/22/	1916	5	Coun Mass	achuse	etts
	P.		Usual Residence of Decedent															
	urylar show	_	10a. State 10b. Coun	•			10c. City, T									11	0d. Inside Ci	•
	Ba-f	cto	MD Mont	gomer	У		Kock	ville									1 X Yes	Z [] 140
	라 다 8 c 2	Director	10e. Street and Number						10f. Zip	Code				10g. Cit	tizen of W	hat Coun	try?	
	23a		804 Carter Roa							20852					S.A.			
	tame	Funeral	11. Marital Status		12. Was De Amed F	orces?		13. V	Vas Dece Yes, spe	dent of Hi cify Cuba	spanic On n, Mexica	igin? (Spe n, Puerto	cify Yes or No Rican, etc.)	)-		- Americ k, White,	an Indian, etc.	
36	hours after death with the Maryland tural', or Itame 23e or 28e-f ehow al Examinat must be notified at	by Fi	1 Never Married 2 M 3 X Widowed 4 Divorc		If Yes, G	2 □ No		1	☐ Yes	2 <b>K</b> ) No	Specify:				Specify:	Whi	<b>t</b> 0	
21215-0036	hour turai		15. Deced			Dates: \		I6a. Deced	lont's Heu	al Casuar	ation			16h K	ind of Bu			
Ċ	"na"	lete	(Specify only high	nest grad	e completea			(Give	kind of wo	rk done d	lurina mos	st of worki	ng	10D. K	and or bus	311162271116	ustry	
12	be filed within 72 ital Hygiene. Id other than "na"evant, Ital Medic	Completed	Elementary/Secondary (0-12 12	)	College	(1-4or 5+		Contr	acti	ng Oi	Efice	r		Fed	era1	Gove	ernmen	t
	be filed wi		17. Father's Name (First, Middle	e, Last)									(First, Middle	<del></del>				
Maryland	should be filed within 72 hours after death with the Marylan nd Mental Hygiene. markad other then "natural", or Itame 23e or 28e-1 ehow imatic event, Ita Medical Evanian must be notified at	To Be	George Ethier								Unkr	Our						
2	2 should and Men is marka aumatic	_	19a. Informant's Name/Relatio	nship (Ty	rpe, Print)			19b. Mailin	g Address	s (Street a			l Route Numb	er, City o	or Town, s	State, Zip	Code)	
	and 2 ealth a n 27 is ner trau		Bernard A. Etl	nier.	Son			804 C	arte	r Roa	ad, R	ocky.	ille, M	[ary]	Land	2085	2	
ē,	- I i i		20a. Method of Disposition				20b. Plac	e of Dispo	sition (Na.	me of	a)		ate	20c. L	ocation - (	City or To	wn, State	
Ę	Pages nent of int: if it		1 X Burial 2 ☐ Crematio 1 4 ☐ Donation 5 ☐ Other			n State		lawn	-			4/11	/2005	Rock	cv:11	e. M	arylaı	nd
altimore,	permit. Pages Department of Important: If I any Injury or one		21. Signature of Funeral Service			1	Tark						nple Tr			, 11	ary rai	
ñ	permit. Departn Importe any inje		NI H	$\mathfrak{I}$ .	14 (	1)	t						, Rocky			ryla	nd 208	352
	-		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.  Approximate											е				
	Physician /Medical		Unset and Death										ween Death					
			disease or condition resulting in death)  a. HSDIYQLI on PNE-MCNIQ  Due to (or as a consequence of):															
Н	Examiner					) 'E	DS i	C										
		er	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence															
	uted d ansit	Examin	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events					tin	C-	NE	det		Lail	7				
'n	exection and and rial-tr		resulting in death) Last		Due to	(or as a	consequer	nce of):	21			6	3					
8760	The law requires that the death certificate be executed the has been signed by the attending physician and oags 2 should be detached for use as the burial-transit	dicai			d\Di	101	250	1	15/	67-	100	9	gil.	Sig	242			
9	rtifica ng ph as th	0	IF FEMALE															
Вох	that the death certif ed by the attending detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant	2	23c. If yes, o 1⊡Live		f pregnance		Ectopic p	regnancy					23d. Date		•	
	deal	Sick	in the past 12 months? 1 ☐ Yes 2 ☐ No			gnant at ti	ime of deat		Other (s						Mon	ith	Day '	Year
0	at the by th	hy	9 Unknown									-						
	ires tha signed t be det	by	Part II. Other significant cond	*	ntributing to			ng in the ur	nderlying (	ause give	en in Part	1.		_			e cause of c	
ord	w require been sig should t	ted	Chicuia		ar.	ria,		9,12	4111	de	ON		1 🗆	Yes 2	No	3 🗌 Prob	ably 4 ∐l	Jnknown
ecc	has be	Completed	CONCN	an	1 0	11	617	7	Di	160	15		24a. Was		24b. W	ere autor	psy findings	available ause of
Œ		Com			-3									rmed?	d	eath? □ Yes		
<u>ita</u>	ilcian: Th certificate rector, pag	Be	25. Was case referred to med	cal							26. Place	e of Death	(Check only	one)				
<b>&gt;</b>	Physic this ce	To	examiner? 1 🗆 Yes 2	1	Hospital:	npatien	t 2□EF	VOutpatien	t 3 🗆 D	Othe Othe	9E 4 □ N	ursing Ho	me 5 Resi	dence	6 🗆 Othe	r (Specify	1)	
0	fter th		27. Manner of Death  1 Natural 5 ☐ Pen	dina	28a. Date (Mo	e of Injury onth, Day	Year) 28	Bb. Time of Injury		28c. Injury Work	at c?		28d. Describe	how inju	ry occurre	ed		
0	endin sath. or: A he fu	atic	2 Accident inve	stigation					М	1 🗆 '	Yes 2	No						
Division of Vital Records,	r Att ter de irectu	Certification:		ld not be rmined			y - At home (Specify)	e, farm, str	eet, factor	y, office			28f. Location ( City or To			er or Rura	l Route Num	ber.
	itai o irs afi ral Di led ir				1													
	To the Hospital or Attending Physician: within 24 hours after death. To the Funaral Director: After this certifica completely filled in by the funeral director.	edical	29a. Certifier (Check only one) 1 Certifier 2 Medic	ying Phy al Exami	ner: On the	basis of e	examination	edge, death n and/or inv	occurred restigation	at the tim	ne, date ar pinion, dea	nd place, a ath occurr	and due to the ed at the time,	cause(s date and	) and mar d place, a	nner as st ind due to	ated. the cause(s	:)
	thin 2 the mple	Med	29b. Signature and title of cert	fier \	and ma	inner state	ea.		29	c. License	number			29d. Da	ite signed	(Month.	Day, Year)	
	F 3 F 8		1 / G	Ch!								1	10	. 1	. : 1	(	100	<
			20 Name and	20.00	ompleted -	ugo of d	oth /!	20) (7)	Driet)	D Cl	1163	- 01	\\	++ B	711	60	50e	2
	11+1		30. Name and address of pers		282	7 de 2	atti (item 2	oa) (Type,	Note:	(	30	· Co	int a	m (	ani	20	V F 8	
	Sta	to	31. Date filed (Month, Day Ye	ar)a	nor 32.	egistrar	r's Signatu	9	20				( i) ( id	0)			- 1	`
•	Registi		APR	12 6	ע כטט	808161	cs D	B	MARK				nta					

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Year Peter Jeffrey Ervin April 10, 2005 2:55 P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 12309 Henry Drive LaVale Allegany If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye 04/16/1947 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 X M 2 ☐ F 57 Director 218-50-0702 Yrs Maryland Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 27 is marked other than "natural", or items 23a or 28a-f show traumstic event, the Madical Examiner must be notified at MD **Allegany** LaVale 1 ☐ Yes 2 🕅 No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12309 Henry Drive 21502 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. filed withIn 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: þ Specify: 3 ☐ Widowed 4 🏋 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "ns any injury or other traumatic event, the Madis once. (Specify only highest grade completed) Temporary Elementary/Secondary (0-12) College (1-4or 5+) 12 0wner Employment Agency 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Jerome Selmore Ervin, Sr. Margaret Elizabeth Zi 1hman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 938 Old Morgantown Road, West. Friendsville, MD 21531 Julie Frazee /sister 20a Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Hillcrest Memorial Park 04/14/2005 \* 4 □Donation 5 □ Other (Specify) Cumberland, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Adams Family Funeral Home, P.A. 404 Decatur Street, Cumberland, Maryland 21502 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Sclerosis **Physician** Due to (or as a consequence of): citeral disease or condition resulting in death) /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine the attending physician and hed for use as the burial-transit requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760 Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No detached 9 Unknown 9 Unknown is been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 20 No 1 Yes 25 No 1 Tes To the Hospitei or Attending Physicien: within 24 hours after death.
To the Funerel Director: After this certifica Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2× No 1 🗌 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1X Natural 5 Pendina 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 💢 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Sign tore and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 5 D23774 April 11, 2005 never SCOCK MD 30. Name and address of person who completed gause of death (Item 23a) (Type, Print) Paul T. Livengood, M.D., 912 Seton Drive, Cumberland, Maryland 21502 31. Date filed (Month, Day, Year) APR 11 32 degistrar's Signature State Registrar

		•	State of Maryland / Dep	ertificate of L			ene 2005	14177		
			Decedent's Name (First, Middle, Last)			2. Date of Death Month		3. Time of Death		
	Physicia /Medic		ANN	Day Yea 2005	4:30 P M					
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or	Location of Death		4c. County of De			
			HOLY CROSS HOSPITAL	SILVER	SPRING		MONT	GOMERY		
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday			8. Date of Birth	(9. B	Birthplace (State or Foreign Country)		
	Director		208-01-9882 1 M 2 F 86 Yrs.	Moritins Days	Hours Min.	8. Date of Birth (Month, Day, ULY 22,	1918	PA		
	D .		Usual Residence of Decedent							
•	aryla shov	_	10a. State 10b. County 10c. City, Town or t	Location				10d. Inside City Limits		
:	Ba-f	cto	MARYLAND MONTGOMERY	SILVER S	PRING			tX∏Yes 2 ☐ No		
	or 2	Director	10e. Street and Number	10f. Zip Code		10	g. Citizen of What	Country?		
	ath w		3005 SOUTH LEISURE WORLD BLVD #223		20906		U.S.A			
	tams	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	. Was Decedent of Hi If Yes, specify Cuba	spanic Origin? (Spe n, Mexican, Puerto I	cify Yes or No- Rican, etc.)	14. Race - Ar Black, W	merican Indian, hite, etc.		
3	s afte	by F	1 □ Never Married 2 □ Married 1 □ Yes 2 🖔 No If Yes, Give Year or Dates:	1 ☐ Yes 2 ☑ No	Specify:		Specify: W	HITE		
3	n 72 hours after death with the Marylan "natural", or Hams 23a or 28a-f show calcul Examiner must be notified at	d b	21	edent's Usual Occupa			Ob Mind of Business			
2	n 72	Completed	(Specify only highest grade completed) (Giv	e kind of work done of DO NOT use retired	luring most of workir	ng '	6b. Kind of Busines	ss/industry		
1	within than	m.	Elementary/Secondary (0-12) College (1-4or 5+)	HOMEMAKER			OWN HO	MF		
3	be filed within 72 hours after death with the Maryland Hygiene. Hygiene. do ther than "natural", or Itams 23a or 28a-f show avant, it e Madical Examiner must be natified at		17. Father's Name (First, Middle, Last)	HOMEMAKER	18. Mother's Name	(First, Middle, M		WIE.		
3	12 should be filed within h and Mental Hygiene. 7 is marked other than " traumatic avant, it a Max	o Be	MAX POLLOCK		SARAH		•	'UNKNOWN''		
	shoul nd Me mark mati	2		ling Address (Street a		l Route Number.				
2	trau			GADSDEN A				20905		
ĵ	1 and Health Iem 27 Ahar tr		20a Method of Disposition 20b. Place of Disp	position (Name of	D		0c. Location - City	or Town, State		
5	Pages nent of h		Cremation State	ematory`or other plac	1					
	if. Puritme			ID MEML GI		2005 F	ALLS CHUR	CH, VIRGINIA		
2	permit. Pages 1 and 2 should be filed within 72 in Department of Health and Mental Hygiene. Department of Health and Mental Hygiene important: If item 27 is marked other than "natu any injury ocothar traumatic avant, It e Modell once.		D	ANZANSKY-C	GOLDBÉRG M			INC.		
	_		23a. Part1. Enter the disease, or complications that caused the death. Do not e	170 ROCKV				LAND 20852		
			shock, or heart failure. List only one cause on each line.  Immediate Cause (Final	mor are mode or dyna	g, 90011 ay oal alao o	roopiiatory arro.	J.,	Interval Between Onset and Death		
	Physician /Medical		disease or condition resulting in death)  a. CHRONIC OBSTRUCTI	VE PULMONA	ARY DISEAS	SE		6 YEARS		
	Examiner		Due to (or as a consequence of):							
		-	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):							
	ted nsit	Examiner	cause. Enter Underlying Cause (Disease or Injury that initiated events  c							
	xecu and al-tra	xar	that initiated events resulting in death) Last C. Due to (or as a consequence of):							
3	icate be executed physician and s the burial-transit	dlcal E								
5	ficate phy: s the	edlo	G							
<	that the death certific ed by the attending p detached for use as	/M/c	IF FEMALE: 23c. If yes, outcome of pregnancy				23d. Date of d	delivery		
á	atter atter	Physiclan/M	in the past 12 months?	☐Ectopic pregnancy ☐ Other (specify)			Month	Day Year		
	y the	ıysi	1 UYes 2 No 9 Unknown							
_	res that th signed by t be detack		Part II. Other significent conditions contributing to death but not resulting in the	underlying cause give	en in Part I.	23e. Did toba	acco use contribute	to the cause of death?		
3	uires sigr ld be	d by	CONGESTIVE HEART FAILURE			1 ☐ Yes	☐ Yes 2 ☐ No 3 【XProbably 4 ☐ Unknown			
5	w requir been si should	Completed	LINIC CANCED			24a. Was an	an 24b. Were autopsy findings available			
פ	has ge 2	m	LUNG CANCER			autopsy	prior 1	to completion of cause of		
<u> </u>	ician: The Certificate herector, page					1 ☐ Yes 2	No 1□Y	es 2 No		
5	ysician: is certific director,	Be c	25. Was case reterred to medical examiner?  Hospital:	ont all DOA Othe	26. Place of Death					
5	Phys rthis raldi	To :	1 X Yes 2 No No Note that 2 Sea. Date of Injury 28b. Time	OIL SEE DON	4   Iddi Silig Flor		nce 6 Other (S	pecify)		
5	ding Ph h. After th funeral	ton	1X Natural 5 ☐ Pending (Month, Day Year) Injury	Worl			Describe how injury occurred			
2	ttand death ctor: y the	Certification;	3 Suicide 6 Could not be 200 Gloss of Laivey. At home form			28f. Location (Str	eet and Number or	Rural Route Number,		
2	lor A after Dire	ertii	4 Homicide determined building, etc. (Specify)			City or Town,		,		
_	To the Hospital or Attanding Physician: The law requires that the death certification 24 hours after death.  To the Fundaral Director: After this certificate has been signed by the attending.  To the Automatal Director: After this certificate has been signed by the attending to the funeral director, page 2 should be detached for use as		29a. Certifier	ath occurred at the time	ne, date and place.	and due to the car	use(s) and manner	as stated.		
	e Ho 24 h a Fur etely	edical	(Check only one)  2 Medicel Examiner: On the basis of examination and/or and manner stated.	investigation, in my of	oinion, death occurre	ed at the time, da	te and place, and o	due to the cause(s)		
	ompl	Me	29b. Signature and title of certifier	29c. License	o number	29	d. Date signed (Mo	onth, Day, Year)		
)			Jam agning		D24543	A	PRIL 11,	2005		
	3		30. Name and address of person who completed cause of death (Item 23a) (Typ	e, Print)						
			JAMES A. ROSSI, 3305 NORTH LEISURE W		, SILVER S	SPRING,	MARYLAND	20906		
	Sta	atė								
	Regist	rar	31. Date filed (Month, Day, Year)  APR 1 2 2005	THE CO						

DHMH 17 Rev 1/2001

			1 - For State Registrar	State of Maryland				ealth ar Death		Re	g. No.	5	417	8
	Physici	an	Decedent's Name (First, Middle, Last)							. Date of Deat Month		Year	3. Time of	Death
	/Medic			earl Toy Fiel	ds					April_	20 Day	2005	0345	A M
	Examin	er	4a. Facility Name (If not institution, give si					Location of	Death			y of Death		
			Laurelwood Care				kton	- K. I			Ceo			
	Funeral Director		5. Social Security Number 6. Sex 215-30-8306	7. Age (In yrs. la	ast birthday) Yrs.	Months	Days	If Under 24 Hours	Min.	Date of Birth (Month, Day, June 22,	1911	Cour	lace (State or try) Land	' Foreign
	and and		10a. State 10b. County	10c. City	, Town or Lo	cation						1	0d. Inside Cit	y Limits
	Mary f sho	ō	Delaware New Cast	le Ne	w Cas	⊦1 <sub>e</sub>							1 X Yes	2 No
	the 288	Director	10e. Street and Number	TO NO	w oub		p Code			11	0g. Citizen of	What Cour	trv?	
	3a or		550 South DuPont Pa	arkway			9720				_	d Sta	-	
	death ma 2	Funerai		2. Was Decedent Ever in U.S	S. 13.			ispanic Origi	n? (Speci	fy Yes or No- can, etc.)	14. Ra	ce - Americ	an Indian,	
9	or ita	교	1 Never Married 2 Married	Armed Forces? 1 Yes 2 No					Puerto Ri	can, etc.)		ack, White,	etc.	
8	72 hours after death with the Maryland natural', or Itama 23a or 28a-f show itsel Examinat must be notified at	ρ	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 ∐ Yes	2 (A) No	Specify:			Spec	<sup>ñy:</sup> Whi	.te	
5-0	72 h	Completed	15. Decedent's Educ (Specify only highest grade	ation completed)	16a. Dece (Give	dent's Usi	ual Occupa	ation during most o	of working	,	16b. Kind of I	Business/Inc	dustry	
21	within iene.	ф	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT	use retired	)			T 11	0		
Maryland 21215-0036	be filed within 72 hours after death with the Marylan stal Hygiene. 3d other than "natural; or itama 23a or 28a-1 show event, the Madical Examinar must be notified at	S	9		НОІ	nemak	er	45 14 4 1			In Her		Home	
gu	be fi	Be	17. Father's Name (First, Middle, Last)							First, Middle, M	Maiden Suma	me)		
Ĕ	should be ind Mental marked o	ို	Mallery Toy	Defeat)	40) 14-70		/21			Harmer	C: -		0.41	
Ma	12 sho hand 7 is ma traum		19a. Informant's Name/Relationship (Typ			•	•			Route Number,	1		,	20
d)	s 1 and 2 should if Health and Mer item 27 is marke other traumatic		Betty P. Rifenbu						ay, I	New Cas				20
Baltimore,	00		1 ☐ Burial 2 X Cremation 3 ☐ Re	miloval monii Stato	ace of Dispo			1 1	pril	21,	West	Chest	er,	
틆	permit. Pag Department important: i any injury o		<ul><li>4 □ Donation 5 □ Other (Specify)</li><li>21. Signature of Funeral Service License</li></ul>		A. Ferr				2005			sylvar	iia	
Ba	Depa Impo any i		21. Signature of Authoral Service Electrise	4:0	H	icks	Home	for F	uner	als, P.	Α.	11	1 010	\O1
			23a. Part1. Enter the disease, or complic	cations that caused the death						et, Elk		тагута	Approximate	
8760,	All yeldical Examiner who be executed white private and the pr	cai Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of the content of the content of the consequence of the content of t	et Ligience of):	Jeun /	aile	LTE						
P.O. Box 68	The law requires that the death certificate be executed to has been signed by the attending physician end to has 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 18 months? 1 □ Yes 2 No 9 □ Unknown	ac. If yes, outcome of pregnar 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de 9 □ Unknown	death 3[	⊒Ectopic (	pregnancy					ate of delive	,	'ear
	w requires tha been signed I should be det	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23e. Did tobacco use contribute to the cause of death?  1  Yes 2 No 3 Probably 4 Inknown			,	
Vital Records,	<i>a</i> □	Completed	-						_	24a. Was a autops perform	у	prior to co	psy findings a npletion of ca 2 No	available ause of
/ita	iclan: Th certificate ector, pag	Be	25. Was case referred to medical examiner?						of Death (	Check only on	е)			
of \	Physiclan: this certification; all director, I	ျှ	1 ☐ Yes 2 No		ER/Outpatie	nt 3 🗆 🗅	The second	4 Princes	sing Home	e 5 ☐ Reside	ence 6 🗆 O	ther (Specif	v)	
	ding After funei	ation:	27. Manner of Seath  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	of M	28c. Injun Worl	yat k? Yes 2.⊡N		d. Describe ho	Describe how injury occurred			
Division	To the Hospital or Attant within 24 hours after deatl To the Funeral Director: completely filled in by the	Certification:	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Ro City or Town, State)			i Route Numi	ber,			
	he Hosp n 24 hou he Funei pletely fil	edical	29a. Certifier (Check only one)  1  Certifying Phys 2  Medical Examir	ician: To the best of my knower: On the basis of examination and manner stated.	wledge, dea tion and/or ir	th occurre nvestigatio	d at the tin in, in my o	ne, date and pinion, death	place, an	d due to the ca	ause(s) and nate and place	nanner as s e, and due to	tated. the cause(s)	)
	To t Withi To tl	Σ	29b. Signature and title of certifier	0			9c. Licens				9d. Date sign		- ,	
}			I Jui ceil N	an MID			1204	1823			4/2	200	5	
	\		30. Name and address of person who co	mpleted cause of death (Item	23a) (Type	Print)	4	31	5/-	CHIH	H51	M	7	
	Sta Regist	ate rar	31. Date filed (Month, Day, Year)	32 Aegistrar's Signa	ture	1	)				/ / /		<del></del>	

			1 _ State	Maryland /		irtment of H <i>tificate of L</i>	lealth and M Doath	lental Hy	6	005	14179
			Registrer  1. Decedent's Name (First, Middle, Last)		Cei	incate of t	Dealii	2. Date of De	Reg. No.		3. Time of Death
	Physici /Medi		Judith F. Gold					April	Day 4,	2005	8:15 P.M
	Examir		4a. Facility Name (If not institution, give street and numb	er)		4b. City, Town, or	Location of Death		4c. Co	unty of Death	1
	Funeral Director		Hebrew Home of Greater W  5. Social Security Number  087-12-2918  Usual Residence of Decedent	ashingto Age (In yrs. last 83		Rockvi If Under 1 Year Months Days	11e If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da Feb • ]	th	ntgomer 9. Birthp Cour 22 New	lace (State or Foreign
	/land		10a. State 10b. County	10c. City, T	own or Lo	cation				1	0d. Inside City Limits
	a-fsh	ctor	Maryland Montgomery	Rocky	ville						1, Yes 2 No
	or 28	Dire	10e. Street and Number			10f. Zip Code			10g. Citizer	of What Cour	itry?
	e 23e	rai	199 Rollins Avenue, Apart			20852				S. A.	
Baltimore, Maryland 21215-0036	be filed within 72 hours efter deeth with the Maryland tal Hygiene. d other then "natural", or teme 23e or 28e-f show event. I'm Modical Exertical must be notified at	by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Morried  12. Was Decede Armed Force 1 Section 1	X No		Vas Decedent of Hi Yes, specify Cuba □ Yes 2∑ No	ispanic Origin? (Spe n, Mexican, Puerto Specify:	ecity Yes or No Rican, etc.)		Race - Americ Black, White, ecify:	
5-0	72 hours "natural", olical Ext	Completed	15. Decedent's Education (Specify only highest grade completed)	1	(Give	ent's Usual Occupa	furing most of worki	na	16b. Kind	of Business/Inc	dustry
121	within ane. then	mpi	Elementary/Secondary (0-12) College (1-4	or 5+)	life. L	OO NOT use retired	)				
9	filed w Hygier other th	Co	12 Years  17. Father's Name (First, Middle, Last)		воо	kkeeper	18. Mother's Name	(First, Middle		Private	
an	ould be Mental arked o	To Be	Samuel Friend					Malamed		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
arv	2 should be filed within 72 ha and Mental Hygiene. Is marked other then "natur eurnatic event, ine Magical	-	19a. Informant's Name/Relationship (Type, Print)				and Number or Rura				
Σ	and and ealth m 27 m		Sidney Gold- Son				nue, Apt.				
ore	Pages 1 and 2 should bent of Health and Mentinit If Item 27 is marked ity or other treumatice		20a. Method of Disposition 1 □Surial 2 □ Cremation 3 ☑Removal from Sta	ale !		sition (Name of natory or other place		ate		ion - City or To	
弄	permit. Pag Department Importent: fi any Injury o		* 4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service Licensee	Welly		Cemetery	4/10/				, New York
Ba	permit. Departn Importe any Injt		Domald C. Lite	77,			Goldberg				
			23a. Part1. Enter the disease, or complications that cau shock, or heart failure. List only one cause on eac	sed the dean. [	Do not ente	r the mode of dying	<mark>ille Pike</mark> g, such as cardiac o	r respiratory a	rrest,	Maryla	Approximate
	Physician		Immediate Cause (Final disease or condition				AL IN				Interval Between Onset and Death
	/Medical Examiner		resulting in death)	as a consequent					1		
	LAGITITIE	Ļ	Sequentially list conditions, b. Due to	as a consequence	IA	RTERY	DISE	ASE			
	nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	as a consequent	ce or):						
^ ~	ficate be executed physicien and is the burlat-transit	Exai	resulting in death) Last	as a consequence	ce of):						
OLD 68760,	ite be iysicie ne bur	edicai	d								
	ng ph		IF FEMALE:								
开 (A. Box	the de	Physician/M	23b. Was decedent pregnant in the past 12 months?	n 2 ☐ Fetal dea t at time of death	ath 3	Ectopic pregnancy Other (specify)			23d	Date of delive Month	ry Day Year
	w requires that been signed b should be deta	by P	Part II. Other significant conditions contributing to deat	h but not resultin	ig in the un	derlying cause give	en in Part I.	23e. Did t	obacco use	contribute to th	e cause of death?
V/V	equire sen sig ould b							10	Yes 2XIN	o 3∏Proba	ably 4 □Unknown
Rec _		Completed						24a. Was auto perfo 1 🗆 Yes		4b. Were autor prior to con death? 1 \(\sum \text{Yes}\)	osy findings available inpletion of cause of
Vital		o Be	25. Was case referred to medical examiner?  1 Yes 2 No Hospital: 1 Inp	ationt 2000	/Outpatient	Othe	26. Place of Death				
美 5	ding Phys h. After this funeral di	$\vdash$	27. Manner of Death 28a. Date of I	njury 28t	b. Time of	28c. Injury Work	- Amily	ne 5∟Hesi 28d. Describe I		Other (Specify courred	)
25	ttendin death. ctor: Aft / the fun	atio	1 Natural 5 Pending (Month), 2 Accident investigation	Day Year)	Injury		r? res 2 □ No				
Onl- Divis	i Sir de	Certification;	3 Suicide 6 Could not be determined 28e. Place of building.	Injury - At home, , etc. (Specity)	, farm, stre	eet, factory, office	2	28f. Location (: City or To	Street and N vn, State)	umber or Rurai	Route Number,
- سام	the Hos in 24 h the Fur	Medical	29a. Certifier Check only one)  2 Medical Examiner: On the basi and manner  20b. Singal One talk of actifier.	s of examination	dge, death and/or inv	estigation, in my op	inion, death occurre	ed at the time,	date and pla	ce, and due to	the cause(s)
	To To		29b. Signature and title of certifier		_	29c. License	I SA SY		A O	gned (Month, E	
	, ,		30. Name and address of person who completed cause of	of death (Itam 33	a) (Tuno F		10001		MICIE	- 05	2005
	10		DINESH D. AT		ал (туре, н  • <b>П</b> •		noxiTra	SE 12	0 2	-OTK VI	LLELID
	Sta Registr			istrar's Signature	A A	mile			1	23,00	

		1	For Stata Registrar	State of Maryland / Depa	artment of Health and rtificate of Death		giene 0 0 5	14180
ı	Physici /Medic		Decedent's Name (First, Middle, Last     JOHN RICHARD			2 Date of De	Day 2005	3. Time of Death 4'55 MM
1	Examin		4a. Facility Name (If not institution, give DOCTORS COMMUNIT	e street and number) CY HOSPITAL	th	4c. County of De		
	Funeral Director		5. Social Security Number 127-36-3156 1	ex 7. Age (In yrs. last birthday) 67 Yrs.	If Under 1 Year If Under 24 Hrs Months Days Hours Min		th 9. E by, Year) 1937	Birthplace (State or Foreign Country) CANADA
	put &		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or Lo	ocation			10d. Inside City Limits
	Maryla -f sho	tor	MARYLAND PRINCE (					1 XYes 2 □ No
	th the or 28e e notil	Director	10e. Street and Number		10f. Zip Code		10g. Citizen of What	Country?
	ath wi	rai	13308 YORKTOWN RO		20900			ES OF AMERICA
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "neturel", or Items 23a or 28e-f show important: If item 27 is marked other than "neturel", or Items 23a or 28e-f show important: If items 27 is marked other than "neturel" or Items 25 on 28e-f show introduce.	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 □ Widowed 4 ☒ Divorced	1 Tyes 2 XNo	Was Decedent of Hispanic Origin? (and the street of Hispanic Arguments of Hispanic Origin? (and the street of Hispanic Origin?) (and the street of Hispanic Origin) (b) And the street of Hispanic Origin) (b) And the street of Hispanic Origin) (b) And the street of Hispanic Origin) (c) And t	Specify Yes or No rto Rican, etc.)	Black, W	merican Indian, hite, etc. WHITE
21215-0036	in 72 ho n "netur	Completed	15. Decedent's Ed (Specify only highest gra	de completed) (Give	dent's Usual Occupation a kind of work done during most of wo DO NOT use retired)	orking	16b. Kind of Busine	ss/Industry
212	filed with Hygiene. Other than	Com	Elementary/Secondary (0-12)	College (1-4or 5+) 5+ LAWY	ER		FEDERAL G	OVERNMENT
Maryland	l be filed ntal Hygi ed other event, I	Be	17. Father's Name (First, Middle, Last) BEN GARSON			ame <i>(First, Middl</i> e, H MILCHIN	, Maiden Sumame) N	
ž	2 should and Men Is marke eumatic	은	19a. Informant's Name/Relationship (	Type, Print) 19b. Maili	ing Address (Street and Number or F			a, Zip Code)
	1 and 2: Health ar em 27 ls kher treu		RUTH MILCHIN - MC					LORIDA 33325
altimore,	Pages 1 Iment of He tant; If iten jury or oth	,	20a. Method of Disposition  1 □ Burial 2 ဩCremation 3 ☐  '4 □ Donation 5 □ Other (Specification)	NATIONAL	CREMATORY 04/	Date 15/05		RCH, VIRGINIA
Ball	permit. Page Department Important; If eny injury or		21. Signature of Euroral Service Licer	Ž	Name and Address of Facility E 1091 ROCKVILLE P	RAL, DIREC	KVILLÈ,™B	<b>•</b> 20852
	Physician		shock, or heart failure. List only Immediate Cause (Final disease or condition	plications that caused the death. Do not en one cause on each line.		_		Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Bue to (or as a consequence of):  13   POCAN	- DISOR	LOE.	~	
	ted	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury	Due to (or as a consequence of):				
90,	ficate be executed physician and s the burial-transit		that initiated events resulting in death) Last	Due to (or as a consequence of):				
68760,	ficate t physics ts the b	edicai	•	d				
.O. Box	that the death certificate be executed tod by the attending physician and detached for use as the burial-transit	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		□Ectopic pregnancy □ Other (specify)		23d. Date of Month	delivery Day Year
<u>α</u>	98	by	Part II. Other significant conditions of	contributing to death but not resulting in the u	underlying cause given in Part I.			e to the cause of death?  Probably 4 Hnknown
Vital Records,	e law has b	Completed				24a. Was autor perfo		
/ita	ician: Th certificate ector, pag	Be (	25. Was case referred to medical examiner?	Haspitalt	Other	eath (Check only o		
i i	Physic rthis ral dir	1: To	1 ☐ Yes 2 ☐XNo 27. Manner of Death	Hospital: 1 XInpatient 2 ☐ ER/Outpatie  28a. Date of Injury 28b. Time of			dence 6 Other (S	pecify)
On	Attending Physician: r death, ector: After this certific by the funeral director,	ation	1 XNatural 5 ☐ Pending investigatio	(Month, Day Year) Injury	Work? M 1 ☐ Yes 2 ☐ No			
Division of	el or Atteno ; after death I Director: d in by the	ertification;	3 Suicide 6 Could not be determined		treet, factory, office	28f. Location ( City or To	Street and Number or wn, State)	Rural Route Number,
	To the Hospitel or At within 24 hours after of To the Funerel Direct completely filled in by	edical C		nysician: To the best of my knowledge, dea miner: On the basis of examination and/or in and manner stated.				
<b>\</b>	To the h within 24 To the F complete	W	29b. Signature and title of confider		29c. License number	2	29d. Date signed (Me	
					D58183		4-1-	-2005
-	12		CECIL DONALD GE		OD LUCK ROAD, LAN	HAM, MD	20706	
	Sta Regist		31. Date filed (Month, Day, Year) 2	2005 32. Signatur	Poorle			

			For State Registrar	State of Marylan		artment of H			giene	5 14181
			Decedent's Name (First, Middle, Last	it)				2. Date of De	ath	3. Time of Death
	Physici /Medic	al	CATHERINE  4a. Facility Name (If not institution, give	M. GOODMA	N	4b. City, Town, or	Logation of D	APRIL	7 2005 4c. County of	
	Examin	er	PRINCE GEORGE'S				ERLY	eam		
	Funeral		5. Social Security Number 6. S		last birthday)	If Under 1 Year	If Under 24 h		h	E GEORGE S  9. Birthplace (State or Foreign
Ш	Director		578-54-0536	□M 2½F 71	Yrs.	Months Days	Hours N	June 13		Country) Virginia
	p ,		Usual Residence of Decedent  10a. State 10b. County	100 6	ty, Town or Lo					
	show	5								10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	ith the Marylar or 28a-f show	Director	MD PRINCE (	GEORGE'S	LANDOV	ER 10f. Zip Code	_		10g. Citizen of Wh	
	aa or		7501 GROUSE PLACE	CE		2078	8.5		U.S.A.	iat Country:
	ms 2:	Funerai	11. Marital Status	12. Was Decedent Ever in U	I.S. 13.	Was Decedent of H	ispanic Origin?	(Specify Yes or No	- 14. Race	- American Indian,
9	or ite	Ē	1 ☐ Never Married 2 X Married	Armed Forces? 1 ☐ Yes 2 No If Yes, Give		f Yes, specify Cuba 1 ☐ Yes 2 🛣 No	n, Mexican, Pu Specify:	uerto Rican, etc.)		, White, etc.
200	i 72 hours after death with the Maryland "natural", or Items 23a or 28a-1 show idical Examinat must be multipal at	d by	3 Widowed 4 Divorced	Year or Dates:		TLI TES ZENINO	<i>Зр<del>в</del>спу.</i>		Specify:	BLACK
<u>5</u>	72	Completed	15. Decedent's Ed (Specify only highest gra	lucation de completed)	(Give	dent's Usual Occup kind of work done	during most of	working	16b. Kind of Bus	ness/Industry
12	within ene. than "	m d m	Elementary/Secondary (0-12)	College (1-4or 5+) 4 yrs		DO NOT use retired CHER	")		GOVERNM	ATZNITE
9	Hyg Hyg ant,		17. Father's Name (First, Middle, Last)		LLA	CHEK	18. Mother's I	Name (First, Middle,		
lan	ould be Mental arked c atic ava	To Be	GEORGE GARNET	Γ			CLARA	TALIFER	RO	
Maryland 21215-0036	d 2 should be th and Mental 7 is marked traumatic av		19a. Informant's Name/Relationship (	Гуре, Print)	19b. Mailir	ng Address (Street a	and Number or	r Rural Route Numbe	er, City or Town, S	tate, Zip Code)
	カモトニ		ALEX GOODMAN/HU		_		PLACE L	ANDOVER, 1		20785
Baltimore,	50 00		20a. Method of Disposition 1 ☐ Burial 2 🛣 Cremation 3 ☐	Removal from State	cemetery, crei	sition (Name of natory or other plac		Date		ity or Town, State
Ë	tment tant:		` 4 ☐ Donation 5 ☐ Other (Specify	) RI	VERDAL	E CREMATO	RY 4/	14/05		E,MARYLAND
Bal	permit. Page Department of Important; if any injury or once.		21. Signa (re of Fundral Service Licen	800				J. B. JER AD LANDOVI		ERAL HOME AND 20785
			23a. Parti. Enter fine disease, or com	olications that caused the deat						Approximate
			shock, or heart failure. List only Immediate Cause (Final	one cause on each line.			3,			Interval Between Onset and Death
	Pnysician /Medical		disease or condition resulting in death)	a. HYPERTENSI						-
	Examiner			b. HYPERCHOLE		IA				
	ъ ≃	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseq						
	ecuter and -trans	Examine	Cause (Disease or injury that initiated events resulting in death) Last	c. CORONARY A		DISEASE				
8760,	be executed sician and burial-transit			Due to (or as a conseq	quence or):					
687	ate hy:	an/Medicai		. d						
Box (	eath certific attending p	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregna		- 6000			23d. Date	of delivery
		icia	in the past 12 months? 1 Yes 2 No	1 Live birth 2 Feta		Ectopic pregnancy Other (specify)			Monti	h Day Year
P.0	at the de by the a stached	Physicia	9 Unknown	9□ Unknown						
Ś	requires that the een signed by th hould be detache	by	Part II. Other significant conditions of	ontributing to death but not res	sulting in the u	nderlying cause give	en in Part I.			oute to the cause of death?
ord	w requir been si should	ted							res 2□No 3	Probably 4X Unknown
Vital Record	g & C1	ompleted						24a. Was autop	sy pri	ere autopsy findings available for to completion of cause of ath?
alF	(0)	O								Yes X No
₹	sicis cerl rect	o Be	25. Was case referred to medical examiner?  1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 🔀	ER/Outpatier	othe Othe	nr.	Death (Check only o		(0
of			27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time o		-	g Home 5 Resid	now injury occurred	
ion	Attending I r death. ector: Alter by the funer	atio	1 XNatural 5 ☐ Pending 2 ☐ Accident investigation		Injury		K? Yes 2□No			
Division		ertification;	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At hi building, etc. (Specif	iome, farm, str	eet, factory, office		28f. Location (S City or Tox		or Rural Route Number,
	ospital or hours afte inaral Dii ly filled in	O								
	Hos Prun ely	edical	29a. Certifier 1 X Certifying Ph (Check only one) 2 Medical Exam	ysician: To the best of my kno niner: On the basis of examina and manner stated.	owledge, deat ation and/or in	h occurred at the tim vestigation, in my op	ne, date and pl pinion, death o	ace, and due to the courred at the time,	cause(s) and manr date and place, an	ner as stated. Id due to the cause(s)
	To the Hos within 24 h To the Fur completely	Mec	29b. Signature and title of certifier	and marrier stated.		29c. License	number		29d. Date signed (	(Month, Day, Year)
	- S F O		Runa	A 12		7/	(22)	1	4/2/	2005
P.	(2)			completed cause of death (Iter	m 23a) (Type,	Prive	50x 1		4/8/0 . MD	~~~
	9			nercantil	e_	Lane	2. 4	argo	. mo	
	Sta Registi		APR 1 3 200	Registrar's Signa	ature	le				

		•	1 - For State Registrar	State of Maryland /		t of Health ar e <i>of Death</i>		giene 005	14182
			1. Decedent's Name (First, Middle, Last)				2. Date of De		3. Time of Death
	Physici /Medic		VINCENT	GREENF	LELD		APRIL	9 2005 Year	3:20 P M
	Examin		4a. Facility Name (If not institution, give st	reet and number)	4b. City,	Town, or Location of D	Death	4c. County of De	ath
			WASHINGTON ADVENT			MA PARK		MONTGOME	
	Funeral		5. Social Security Number 6. Sex	M 2□ F	Yrs. If Under	1 Year If Under 24 Days Hours	Min. (Month, Da		irthplace (State or Foreign Country)
	Director		Usual Residence of Decedent	68	113.		April	19 1936 MA	RYLAND
	yland sow		10a. State 10b. County	10c. City, Tov	vn or Location				10d. Inside City Limits
	Mar B-f st	tor	MD PRINCE GEO	ORGE'S UP	PER MARLI	SORO			1 Yes 2 □ No
	th the	Director	10e. Street and Number	,	10f. Zip			10g. Citizen of What C	Country?
	238 238 1		15115 Marlboro	?ike	20	)772		U.S.A.	
	tems	Funeral		Was Decedent Ever in U.S.     Armed Forces?	13. Was Dece	fent of Hispanic Origin cify Cuban, Mexican, F	n? (Specify Yes or No Puerto Rican, etc.)	- 14. Race - Arr Black, Wh	
36	hours after death with the Maryland tural; or Items 23a or 28a-f show al Everither must be invitited at	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1  Yes 2 □ No Navy If Yes, Give Year or Dates:	1 🗀 Yes	2K No Specify:		Specify:	BLACK
9	tural	edt	15. Decedent's Educ		. Decedent's Usua	al Occupation		16b. Kind of Busines	s/Industry
212	filed within 72 Hygiena. Ither than "nai ent, Ire Madic	Completed	(Specify only highest grade Elementary/Secondary (0-12)		(Give kind of wo life. DO NOT u	rk done during most of	f working		2
212	d with giena er tha	mo.	12th	College (1-401 37)	Truck D	river		Private	
p	al Hygi al Hygi dother vent, I	Be	17. Father's Name (First, Middle, Last)			18. Mother's	Name (First, Middle,	Maiden Sumame)	
<u>X</u>	should be filed within 72 hours after death with the Marylar and Mental Hygiena.  In a marked other than "natural; or thems 23a or 28a-f show a marked other than "natural; or thems 23a or 28a-f show umatic event, in a Madical Eversiner must be notified at	2	William Greenfiel				y B. Barbe		
Maryland 21215-003	2 shu and Ism raum		19a. Informant's Name/Relationship (Typ		•	•		er, City or Town, State,	zip Code) yland 20772
e,	permit. Pages 1 and 2 should by Department of Health and Menta Important: If Item 271s marked any injury or other traumatic events.		Mary Greenfield/Wi		of Disposition (Nar		Date Date	20c. Location - City of	
altimore,	ages nt of I		1 ☑ Burial 2 ☐ Cremation 3 ☐ Re	moval from State cemete	ery, crematory or o	ther place)			
를	nit. Pa artme ortani injury		'4 □ Donation 5 □ Other (Specify)  21. Signatur of Fragal State and State of State	Resur		Cemetery 4		Clinton, Ma	
Ba	Dep Impo		MINISTER					nkins Funer er, Marylan	
			23a. Part1. Enter the disease, or complic	ations that caused the death. Do					Approximate
L	nysician		shock, or heart failure. List only one Immediate Cause (Final		الاا . ور الا	4			Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	Due to (or as a consequence	*	e Comb			1
	Examiner	1. []	Sequentially list conditions, b.		-16				25 min
	p ii	iner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence	of):				
	ecute and I-tran	Examiner	that initiated events c. resulting in death) Last	Due to (or as a consequence	of):				
8760,	The law requires that the death cartificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	aiE							
687	ficate p phys	edicai	d.						
Вох	leath cartific attending p	n/M	IF FEMALE: 23b. Was decedent pregnant	c. If yes, outcome of pregnancy	• CDE			23d. Date of d	əlivery
ū.	death e atte	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	h 3 ⊟Ectopic pi 5 ⊟ Other <i>(sp</i>			Month	Day Year
P. O.	at the de by the a stached	hys	9 🗆 Unknown						
s S	res that igned to be det	by	Part II. Other significant conditions cont	ributing to death but not resulting		•		obacco use contribute	
ord	w requir been si should b	ted	Coronary and	and contract	11011	Quoune 1			<sup>5</sup> robably 4 □Unknown
Records,	The law cate has b page 2 sl	Completed					24a. Was	an 24b. Were a prior to death?	autopsy findings available completion of cause of
							1 es		s 25No
Vita	sician: certific rector.	o Be	25. Was case referred to medical examiner?	ospital:			Death (Check only of		
Division of	Phys or this oral dis	-	1 ☐ Yes 2 ☐ Mo		The same last to	8c. Injury at Work?		dence 6 Other (Sp	acify)
ion	nding P ath. r: After e funera	ation	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury M	Work? 1 ☐ Yes 2 ☐ No			
<u>N</u>	al or Attendi after death. I Director: A d in by the fu	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At home, f building, etc. (Specify)	arm, street, factory	, office	28f. Location (S	Street and Number or F	?ura! Route Number,
	talor rsafte al Dir	Cerl	- Inditional	building, sto. (opedity)			01.9 07 701	vii, otato)	
	or the Hospital or Attending Physician: within 24 hours after death as a feet this certificator the Funeral Director. After this certificator pletely filled in by the funeral director.	Medical	29a. Certifier 1 Certifying Physical Check only 2 Medical Examin	ician: To the best of my knowledger: On the basis of examination and manner stated.	e, death occurred nd/or investigation	at the time, date and p , in my opinion, death	place, and due to the occurred at the time,	cause(s) and manner a date and place, and du	is stated. ie to the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier		290	:. License number		29d. Date signed (Mor	nth, Day, Year)
0			Toma Moi	lehy		59691		4 -	-20- F
2	(1)		30. Name and address of person who cor	npleted cause of death (Item 23a)	(Type, Print)	- 7 :			
			TAREL A	npleted cause of death (Item 23a)	tua s	+11 SAR	VIS AUG.	STE 100 K	WEXDALL MO
	Sta Registi		31. Date filed (Month, Day, Year)  APR 1 3 2005	7. Registrar's Signature	horse				437

				e of Maryland / De			-		
			_ State	-	ertificate of			71115	14183
			Registrar  1. Decedent's Name (First, Middle, Last)		Crimcate Of	Death	2. Date of Dea	leg. No.	3. Time of Death
	Physici		David Livingston Gord	on			Month April 1	LO, 2005	11:38am
	/Medio Examir		4a. Facility Name (If not institution, give street and		4b. City, Town, o	or Location of Death	przz .	4c. County of Deat	
			Suburban Hospital		Bethesd	а		Montgom	ery
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birthda	Months   Davs	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day	y Year) 9. Birt	hplace (State or Foreign
	Director		120-07-6166 Usual Residence of Decedent	88 Yrs.			Nov. 18	3, 1916 Geo	rgia
	/land		10a. State 10b. County	10c. City, Town or	Location				10d. Inside City Limits
	Man B-f eh	ţoţ	Maryland Montgomery	N. Bethe	sda				1 ☐ Yes 2 🗷 No
	th the	Director	10e. Street and Number		10f. Zip Code		1	10g. Citizen of What Co	untry?
	death with the Maryland ms 23a or 28a-f ehow r nust be notified at		5550 Tuckerman Lane #		2085			Jnited Stat	es
	er de: Items	Funeral	Arme	Decedent Ever in U.S. 1: d Forces?	<ol> <li>Was Decedent of H If Yes, specify Cub</li> </ol>	lispanic Origin? (Spe an, Mexican, Puerto I	cify Yes or No- Rican, etc.)	14. Race - Ame Black, White	
36	rs aft	by F	If Yes	es 2X No Grive or Dates:	1 ☐ Yes 21 No	Specify:		Specify:	hite
9	2 hou atura		15. Decedent's Education	16a De	cedent's Usual Occup	pation		16b. Kind of Business/	
215	thin 7.	ple	(Specify only highest grade completed in the complete in the c	ge (1-4or 5+) (Gi	ve kind of work done . DO NOT use retire	during most of workir d)	19		
21	be filed within 72 hours after death with the Marylan ntal Hygiene. bd other than "natural", or flems 23a or 28a-f ehow evant, the Modical Extendent must be notified at	Completed			nomist			World Bank	
pu	be fill tal Hy doth	Be	17. Father's Name (First, Middle, Last)			18. Mother's Name		Maiden Sumame)	
<u> </u>	J Mer narke natic	L <sub>O</sub>	Arthur Hale Gordon	105.14	Illa - A dda /Canaa	Harriet M			T 0 ()
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or ite any injury or other traumatic event, the Modical Extenditua		19a. Informant's Name/Relationship (Type, Print) Frances Mangum (Dau			Road, Pot		r, City or Town, State, 2 m. 2085/	up Code)
ē,	s 1 an I Hea Itam S		20a. Method of Disposition	20b. Place of Dis	position (Name of	. D		20c. Location - City or	Town, State
ê ê	Page ent o		1 ☐ Burial 2 ☆Cremation 3 ☐ Removal f  '4 ☐ Donation 5 ☐ Other (Specify)	rom State	rematory`or other pla litan Creπ	natory 4/1	1/05	Alexandria	Vircinia
a	mit. partm porta y inju		21. Sign turn of Funeral Service Licensee	-	22. Name and Addre	ess of Facility De	Vol Fun	eral Home	, ,
Ω.	e a m c a	i 13	I fuzil. W	1	Gaithersbu	er Park D irg, MD 20	71ve 877		
			23a. Part1. Enter the disease, or complications t shock, or heart failure. List only one cause	hat caused the death. Do not a on each line.	enter the mode of dyir	ng, such as cardiac o	r respiratory arr	est,	Approximate Interval Between
	Physician	6	Immediate Cause (Final disease or condition	cardial Infar	ction				Onset and Death  1 Day
	/Medical Examiner		resulting in death)	e to (or as a consequence of):					
		-	Sequentially list conditions, b.	e to for as a consequence of:					
	uted I Insit	Examiner	cause. Enter Underlying Cause (Disease or injury	,					
,	e be executed /sician and e burial-transit	Exa	that initiated events cc	e to (or as a consequence of):					
1760,		cal	d						
Box 68	ntifica ng ph s as th	an/Med	IF FEMALE:						-
903	ath ce ttendi or use	lan/I	23b. Was decedent pregnant 10LL		B Ectopic pregnancy	у		23d. Date of deli Month	very Day Year
- 0	the a	Physicia	1 Ves 2 No	regnant at time of death ( Inknown	5 ☐ Other (specify) _				Day . ou.
نه ۶	that the d ed by the detached	/ Ph	Part II. Other significant conditions contributing	to death but not resulting in the	underlying cause giv	ven in Part I.	23e. Did to	bacco use contribute to	the cause of death?
₹å	w requires that been signed b should be deta	d by	Aortic Stenosis				1 🗆 Y	es 2XINo 3∐Pr	obably 4 Unknown
38 Ar Records,	g 8 0	Completed	Renal Failure				24a. Was a		topsy findings available completion of cause of
		Соп	Atrial Fibrillation				perform 1 Yes	med?   death?	2 □ No
Vite O	ician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?  Hospital:		Oth	26. Place of Death	(Check only or	19)	
Do	Phys this ral dir	. To	TU Tes ZIX NO	1 ☑ Inpatient 2 ☐ ER/Outpat Date of Injury 28b. Time		4   Nursing Hom		ence 6 Other (Spec	cify)
S Co	Attending Physician: r death. ector: After this certific by the funeral director.	tlon	1 Accident 5 Pending ( 2 Accident investigation	Date of Injury Month, Day Year)  28b. Time Injury	/ Wor			ow injury bookings	
d Gordon OS Division of Vital	or Attenation death	ifica	3 Suicide 6 Could not be determined 28e. F	Place of Injury - At home, farm,	street, factory, office	2	8f. Location (Si	treet and Number or Ru	ral Route Number,
000	tal or s afte al Dir	Certification:	4 Nomicoe	uilding, etc. (Specify)			City or Town	n, Siare)	
DANIA BOCADO H-10-05 Division of Vit	To the Hospital or Attending Physwithin 24 hours after death.  To the Funeral Director: After this completely filled in by the funeral di	Medical	(Check only 2 Medical Exeminer: On t	o the best of my knowledge, de the basis of examination and/or					
4	To tha within 2 To tha comple	Mec	29b. Signature and title of certifier	manner stated.	29c. Licens	e number	2	9d. Date signed (Monti	n, Day, Year)
	r ≤ r ō		AR I	ID		D 0060117	Benefitzikenjaniste	4/11/2005	
_	1		30. Name and address of person who completed					,	
-	CH150 A		Eric J. Park, M.D. 9	901 Medical Ce	nter Driv	e, Rockvil	le, MD	20850	
	Sta		31. Date filed (Month, Day, Year) APR 1 2 2005	Registrar's Signature	ade				
	Registr	ar	MLK T 2 5003	אלין אין נאושט					

		_	1 - For Stete Registrer	State of Maryland		artment of F tificate of I			Reg. No.		4 84
	Physicia		1. Decedent's Name (First, Middle, La:		REN	6		2. Date of De Month	Day		3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give		7. 10		Location of Death		<b>O</b> 4c.	County of Death	
			HOWARD COUNTY GEN		think do a	COLUMBIA If Under 1 Year	If Under 24 Hrs.	To 5		WARD	
	. Funeral Director		5. Social Security Number 6. S 579-46-5180	ex 7. Age (In yrs. last	Yrs.	Months Days	Hours Min.	8. Date of Bin (Month, Da 11/07/1	th ly, Year) .935	Coun	lace (State or Foreign try) NGTON, DC
	and w		Usual Residence of Decedent  10a. State 10b. County	10c. City, 1	own or Lo	cation					0d. Inside City Limits
	Maryl	ţō	MARYLAND HOWARD	COLUM	1BTA					1	1∭ Yes 2 No
	or 28e	Director	10e. Street and Number			10f. Zip Code			10g. Citi	zen of What Coun	try?
	s 23a	rai	5743 YELLOWROSE C		1.0.	2104			U.S		
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show injury or other traumatic event, the Medical Examination until be notified at an once.	by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 XDivorced	12. Was Decedent Ever in U.S. Armed Forces? 1 MYes 2 □ No If Yes, Give Year or Dates:UNK NOW		Was Decedent of H fYes, specify Cuba 1 □ Yes 2ሺ No	ispanic Origin? (S) in, Mexican, Puerto Specify:	pecify Yes of No o Rican, etc.)	-	14. Race - Americ Black, White, of Specify:	
ည်	72 hou natura		15. Decedent's Ed (Specify only highest gra	ducation	6a. Deced	dent's Usual Occup	ation	ting	16b. Kii	nd of Business/Inc	
121	vithin 7	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life. L	DO NOT use retired	1)	King			
2	filed v Hygie other t	(a)	17. Father's Name (First, Middle, Last)		RAPH	IC ARTIST	18. Mother's Nam	ne (First, Middle,		ERAL GOVI	ERNMENT
/lan	ould be Mental Marked c	<u>m</u>	ABRAHAM	GOLDBERG			YETTA		]	BRODSKY	
Maryland 21215-0036	12 sho h and la mu reum		19a. Informant's Name/Relationship (	1		ng Address (Street					Code)
ē,	t and Health tem 27 other tr		SONDRA MANDELL/SI  20a. Method of Disposition	STER 5	743 e of Dispo	YELLOWROS sition (Name of natory or other place	E CT., C	OLUMBIA Date		21045 cation - City or To	wn, State
Ē	Pages thent of I tant: If It lighty or o		1 X Burial 2 ☐ Cremation 3 ☐  `4 ☐ Donation 5 ☐ Other (Specify	I tellioval holii State		natory or other plac I • GARDEN		7/2005	OLME	Y, MARYL	ANTO
Baltimore,	permit. Page Department Important: If any injury or once.		21. Signature of Funeral Service Licer		EĎĨ	WARD SAGE	ss of Eacility L FUNERA	L DIRECT	TION.	INC.	
	40 = 8 a		23a. Part 1. Enter the disease, or com	plications that caused the death.	μυ:	AT KOCKAT	LLE PIKE	, ROCKV	ILLE,	MD 2085	2 Approximate
	Physician		shock, or heart failure. List only immediate Cause (Final disease or condition	one cause on each line.							Interval Between Onset and Death
	/Medical Examiner		resulting in death)	a. RESPI	ice of):	1 7 7 7 7 7 7	- Name	<del></del>			2 4 100 10
	- Adminici	er	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a consequen	Eu m	onib	-				
	cuted nd ranslt	amin	Cause (Disease or injury that initiated events		psis						
60,	ificate be executed g physician and as the burial-transit	edical Examiner	resulting in death) Last	Due to (or as a consequer	,			e'us			W 95 4 4 5
68760	flicate physics the f	edica		d. CHRIME	7 141	MAN DEFI	rancy VII	( 43			YFRAS
Box	th certi ending r use a		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnance		Ectopic pregnancy			2	23d. Date of delive	•
о. П	The law requires that the death certif ite has been signed by the attending page 2 should be detached for use a	by Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐ Pregnant at time of deat 9☐ Unknown		Other (specify)				Month	Day Year
Ω.	s that t ned by e detac	y Ph	Part II. Other significant conditions of	ontributing to death but not resulting	ng in the ur	nderlying cause give	en in Part I.	23e. Did to	obacco u	se contribute to th	e cause of death?
Division of Vital Records,	equire sen sig ould b	ted b	- DEPRESSION					10	Yes 2,	ZNo 3 ☐ Proba	ably 4 Unknown
ec Sec	e law r has be je 2 sh	Completed	- WLCENATI	ir cours				24a. Was autop		24b. Were autor prior to con death?	psy findings available appletion of cause of
Tal	ificate or, pag	e Co	25. Was case referred to medical				26. Place of Dea	1 ☐ Yes	2 No	1 Yes	2 No
Ž	nysicle nis cert direct	To B	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatient 2 ER	/Outpatien	t 3 DOA Oth	ar			S □Other (Specify	)
o no	ing Pł		27. Manner of Death 1 ☑Natural 5 ☐ Pending	(Month, Day Year)	b. Time of Injury	28c. Injun Worl	ς?	28d. Describe	how injury	y occurred	
/isid	Attending Physiclen: ir death. ector: After this certifice by the funeral director; p	ficat	2 Accident investigation 3 Suicide 6 Could not b	e 28e. Place of Injury - At home	a, farm, str		Yes 2 □ No	28f. Location (S	Street and	d Number or Rura	Route Number,
á	tal or A	Certification:	4  Homicide determined	building, etc. (Specify)				City or Tov	wn, State)	)	
	To the Hospital or Attending Physiclen: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical	29a. Certifier 1 ☐ Certifying Ph (Check only one) 2 ☐ Medicel Exer	ysicien: To the best of my knowle niner: On the basis of examination and manner stated.	dge, death and/or inv	occurred at the tin vestigation, in my o	ne, date and place, pinion, death occur	, and due to the rred at the time,	cause(s) date and	and manner as sta place, and due to	ated. the cause(s)
	To the Hospital within 24 hours a To the Funeral completely filled	Me	29b. Signature and title of certifier	and mainter stated.		29c. License	e number		29d. Date	e signed (Month, L	Day, Year)
)	-		Jen E 1	edans		p 2	F210		/	apr 05	2005
	6		30. Name and address of person who			Print)					
			STERRY SEBO	1070 LO70	0 (1	meskn a	. / 101.	Mp. 2	1046	L	

14185

		1 - State Registrar		Cer	tificate of De	ath	f	Reg. No.	
Physici /Medic		1. Décedent's Name (First, Middle, Last) Mohammad Ali Gha					2. Date of Dea April 1	5, Day 2005 Ye	ar 05 05 M
Examir		4a. Facility Name (If not institution, give s			4b. City, Town, or Loc	ation of Death		4c. County of E	Death
		Suburban Hospital 5. Social Security Number 6. Sex		use lost high doul	Bethesda If Under 1 Year   If	Under 24 Hrs.	9 Date of Bird	Montgo	mery
Funeral Director			7. Age (III	yrs. last birthday) Yrs.		lours Min.	B. Date of Birt (Month, Da Jan 1,	1923	Birthplace (State or Foreigr Country) I ran
yland sow		10a. State 10b. County		c. City, Town or Loc	cation				10d. Inside City Limits
Man B-f sh	ţo	Maryland Montgome	ery B	ethesda					1 □ Yes 2V No
h with the 23e or 28d	Funeral Director	10e.Street and Number 10250 Westlake Driv	ve, #518		10f. Zip Code 20817			10g. Citizen of Wha U.S.of	
permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Infordent: If time 27 is marked other than "netural", or Items 23e or 28e-f show eny Injury or other treumatic event, Ite Modical Exp. it is in an to notified at once.	b	11. Marital Status  1 □ Never Married 2 ☒ Married  3 □ Widowed 4 □ Divorced	12. Was Decedent Ever Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	If	Vas Decedent of Hispa i Yes, specify Cuban, N Yes 2000 No S	nic Origin? (Spedexican, Puerto	ecify Yes or No Rican, etc.)		American Indian, Vhite, etc. 11te
72 ho	sted	15. Decedent's Educ (Specify only highest grade	cation	16a. Deced	ent's Usual Occupation kind of work done durin	n na most of work	ina	16b. Kind of Busine	ess/Industry
ed within giene. er than "	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	Manage	OO NOT use retired)		9	0il/Energ	у
2 should be file and Mental Hy Is marked oth eumatic event	To Be (	17. Father's Name (First, Middle, Last) Abdolsamad Ghaffa	ari			. Mother's Name Robabeh	(First, Middle, Ghaffa	Maiden Sumame)	
nd 2 should be file Ith and Mental Hy 27 Is marked oth r treumatic event	ľ	19a. Informant's Name/Relationship (Type			g Address (Street and				
and ealth m 27		Harry R. Ghaffari-			2 Danehurst		T		
Pages 1 nent of H int: If ite		20a. Method of Disposition  1   Surial 2 □ Cremation 3 □ R  4 □ Donation 5 □ Other (Specify)	emoval morn state		sition (Name of natory or other place) Memory Ga		1°22,	20c. Location - City Manassas	
permit. Pag Department Importent: I eny Injury o		21. Signature of Funeral Service License	99 \	. 22	. Name and Address o	f Facility			-
Pnysician /Medical Examiner	her	23a. Part 1. Enter the disease, ar complisheck, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions,	ications that caused the ne cause on each line.  Due to (or as a co	onsequence ff):	er the mode of dying, s	uch as cardiac	or respiratory a	rrest,	Approxima interval Between Onset and Death Minutes
eath certificate be executed attending physician and for use as the burial-transit	/Medical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to or as a co	onsequence of):	·á				days
death of attended for us	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No	23c. If yes, outcome of p 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at tim 9 ☐ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of Month	f delivery Day Year
iaw requires that the as been signed by th 2 should be detache	by	Part II. Other significant conditions con	ntributing to death but n	ot resulting in the ur	nderlying cause given i	n Part I.			e to the cause of death? ☐ Probably 4 ☐ Unknow
The law requir ate has been si page 2 should	Completed						24a. Was autoj perfo 1 🗆 Yes	osy prior deal	e autopsy findings available r to completion of eause of th? Yes 2 No
cat		25. Was case referred to medical	de anitali.		Othor	6. Place of Deat	A comment of the same		
icien: T certificate rector, pa	Be	examiner?			+ 2 DOA	4 Nursing Ho	me 5 Resi	dence 6 Other (	
ng Physicien: Iter this certifican neral director,	To B	1 Yes 2 No 27. Mann of Death 1 Natural 5 Pending	1 Inpatient 28a. Date of Injury (Month, Day Ye	2 ☐ ER/Outpatien 28b. Time of Injury	28c. Injury at Work?			how injury occurred	Specify)
Attending Planders reference After the by the funera	To B	1 Yes 2 No	1 Inpatient	28b. Time of Injury	28c. Injury at Work?  M 1 \[ Yes		28d. Describe	how injury occurred  Street and Number of	Specify) or Rural Route Number,
Hospitel or Attending Pl 4 hours after death. Funerel Director: After the ety filled in by the funera	Certification; To B	1 Yes 2 No  27. Mann of Death  1 Autural 5 Pending investigation 3 Suicide 4 Homicide 6 Could not be determined  29a. Certifier 10 Certifying Phy	28a. Date of Injury (Month, Day Ye	28b. Time of Injury  - At home, farm, stri  Specify)  ny knowledge, death amination and/or inv	d 28c. Injury at Work?  M 1 ☐ Yes  eet, factory, office	2 □ No	28f. Location ( City or Total	how injury occurred  Street and Number own, State)  cause(s) and manner	or Rural Route Number, ar as stated.
or Attending Platter death. Director: After the in by the funera	To B	1 Yes 2 No  27. Mann of Death 1 1 atural 5 Pending investigation 3 Suicide 6 Could not be determined  29a. Certifier 1 Certifying Phy (Check only 2 Medical Exami	28a. Date of Injury (Month, Day Ye 28e. Place of Injury building, etc. (Sician: To the best of mer: On the basis of ex and manner stated	28b. Time of Injury  - At home, farm, stre Specify)  ny knowledge, death amination and/or invi	at the time, vestigation, in my opini	2 □ No  date and place, on, death occur	28f. Location ( City or Tota and due to the red at the time,	how injury occurred  Street and Number own, State)  cause(s) and mannedate and place, and	or Rural Route Number, ar as stated. due to the cause(s)

State

Registrar

APR 2 6 2005

			For State Registrar				ent of H	lealth and M Death	ental Hygi	•	14186
	Physicia		1. Decedent's Name (First, Middle,	Last)					2. Date of Death Month	h Day Yea	3. Time of Death
	/Medica	1	James N.		ton Jr.				April	11, 2005	8:30 A M
	Examine		4a. Facility Name (If not institution,					Location of Death	10.2	4c. County of De	
			Salisbury Nursing 5. Social Security Number		b Cente Age (In yrs. las		ider 1 Year	Salisbury A		Wicomico	
	Funeral Director		006-10-5635 Usual Residence of Decedent	***	84	Yrs. Mont		Hours Min.	8. Date of Birth (Month, Day, 3/26/19:	Year) 9. 5. 2. 2. 2. 2. 2. 2. 2. 2. 2. 2. 2. 2. 2.	Birthplace (State or Foreign Country) aine
	yland		10a. State 10b. County		10c. City,	Town or Location					10d. Inside City Limits
	e Ma	01 01 01	Maryland Wicon	uico	S	alisbury					1 ☐ Yes 2 🛣 No
	Maith th	Funeral Director	10e. Street and Number 28680 Ocean Gat	eway			Zip Code 21801		10	0g. Citizen of What USA	Country?
	deet ms 2	ner	11. Marital Status	12. Was Decede Armed Force	ent Ever in U.S.	13. Was De	ecedent of H	ispanic Origin? (Spe In, Mexican, Puerto I	cify Yes or No-		nerican Indian,
9036	72 hours after deeth with the Maryland nature!, or items 23a or 28a-f show alcul Evant at most terrorities at	2	1 Never Married	d 1 XYes 2 If Yes, Give			s 2 X No		Hicari, Bic.)	Black, Wi	white
PON 21215-0036	c * 3	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	Education grade completed) College (1-4d			work done o Tuse retired	during most of workir f)	ng 1	16b. Kind of Busines	ss/Industry
HAMILTON ryland 212		5	12			Merchan	t Seam				t Marine
	三工艺艺	DG CC	17. Father's Name (First, Middle, La					18. Mother's Name		faiden Sumame)	
HAMIL: aryland	and Mental	0	James N. Hamilt						Holland		
· =	s 1 and 2 should f Health and Mer Item 27 is marke other treumatic		Norma W. Hamil					and Number or Rura Sateway, S			
S -	s 1 and 2 of Health Item 27 I	Ì	20a. Method of Disposition		20b. Plac	ce of Disposition /	Name of	i D		20c. Location - City	
JAMES	0 0		1 Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spe		Spri	netery, crematory nghill M	<i>lemory</i>	4/15	/05	Hebron, M	1D
JAMES 1 Baltimore,	pernit. Pag Department Importent: I any injury o		21. Signature of Funeral Service Li		CFSP	Gardens Holl	and Addres		me Profe	essional	Association
	Physician /Medical Examiner	ler	23a. Part 1. Enter the disease, or concerns shock, or heart failure. List of immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	a. Dug.to (or	sed the death. h line. as a conseque as a conseque	Do not enter the r  Can  nce of):  Aclco	mode of dyin	g, such as cardiac o	r respiratory arre	ist,	Approximate Interval Between Onset and Death  GRACE  Approximate Interval Between Onset and Death
x 68760,	te be ysicie	icai Ex	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or d	as a conseque						
P.O. Box	Physicien: The law requires thet the death certifical this certificate has been signed by the attending phoral director, page 2 should be detached for use as the contract of	Pnysician/med	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 Live birth	n 2 ☐ Fetal di tat time ol dea	eath 3□Ectopi	c pregnancy (specify)			23d. Date of d Month	lelivery Day Year
	n signed build be deta	2	Part II. Other significant condition	s contributing to deat	h but not resulti	ing in the underlyin	ng cause give	en in Part I.			to the cause of death?  Probably 4 Denknown
Reco	The law requir ate has been si page 2 should	Completed							24a. Was an autopsy perform	prior t death	autopsy findings available o completion of cause of ?
Ita	ysicien: This certificate director, pag	De	25. Was case referred to medical examiner?				177	26. Place of Death			
of V	g Physic er this co	0	1 Yes 2 No 27. Manner of Death	Hospital: 1 Inpa	atient 2 Ef	8b. Time of	DOA Othe	4 at ursing Hon		nce 6 Other (Saw injury occurred	pecify)
Division of Vital Records,	or Attending 6 effer death. Director: Affer d in by the funer	Certification:	1  Accident	tion t be 28e. Place of		Injury M e, larm, street, lac		Yes 2 □ No	81. Location (Str. City or Town,		Rural Route Number,
		Medical Ce	29a. Certifier 1 Certifying (Check only one)	Physician: To the be kaminer: On the basis	s of examinatio	edge, death occur n and/or investigat	red at the tim tion, in my op	ne, date and place, a pinion, death occurre	and due to the ca	use(s) and manner Ite and place, and d	as stated. ue to the cause(s)
	To the vithin To the comple	⊠	29b. Signature and title of certifier	rf)			29c. License	number	D 29	d. Date signed (Mo	nth, Day, Year)
	0 26		70////	Than	-6.4 #:		02	754		4/17/	15
_	25		30. Name and address of person w	M.D. 200	CIVIC	AVE., SAL	ISBUR	Y, MD. 2]	1804	- /	
	State Registra		31. Date filed (Month, Day, Year) $ \begin{array}{c} \text{APR} \ 1 \ 3 \end{array}$	2005 32.	istrar's Signatur	& Socie	2)				

DHMH 17 Rev 1/2001

### Pleas

Please Type or Print	in Black Indelible Ink. Ensure A	ll Copies Are Legible.	
	yland / Department of Health and N	Mental Hygiene 05	14187
tate egistrar	Certificate of Death	Reg. No.	
cedent's Name (First, Middle, Last)		2. Date of Death Month Day Year	3. Time of Death
HERBERT HARRISON		April 9, 2005	11:57 A.M

**Physician** /Medical **Examiner** 

1 - For State Registrar

1. Decedent's Name (First, Middle

4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Prince George's Hospital Center Cheverly Prince George's If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 ★M 2 F Yrs. Director 579-38-5432 Washington, DC May 6, Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location itam 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Madical Examiner rust for notified at 1 Tyes 2 □ No Prince Georges Lanham Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20706 9602 Linwood USA Ave. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 ☐ No Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Public School Mail Supervisor 5th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) . Pages 1 and 2 should be fit iment of Health and Mental H tant: If itam 27 Is marked ott Be Leroy Harrison Louise Peyton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Ann Harrison/Wife 9602 Linwood Ave. Lanham, MD 20706 20a. Method of Disposition 20b. Place of Disposition (Name of cometery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 【ACremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. Riverdale Crematory Apr. 18, 2005 Riverdale, MD \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Johnson and Jenkins Funeral Home 716 Kennedy St. NW Washington, DC 20011 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, k, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** List resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of): The law requires that the death certificate be executed use as the burial-transit that initiated events attending physician and resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 DUnknown this certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 🗆 No 1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) toxYes 2 □ No 1 Inpatient Certification: To 2XXER/Outpatient 3☐ DOA 28a. Date of Injury (Month, Day 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred tget Slot 1 Natural 5 Pending investigation 1 🗌 Yes the 2 Accident within 24 hours after deat To the Funeral Diractor; AM 6 Could not be Location (Street and Number or Rural Route Number City or Town, State) 9602 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 9602 Linkowa May (acong 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) OCME April 10, 2005 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 Penn Street Baltimore, Maryland 21201 THE WORE MILLING 31. Date filed (Month, Day, Year)

State

Registrar

Registrar's Signature

APR 1 3 2005

			For State	State of Ma	aryland / Dep	artment of H		- '	giene	005	11.100
			Registrar  1. Decedent's Name (First, Midd	lle, Last)		rimoulo of L	204111	2. Date of Dea	ath	UUD.	3. Time of Death
п	Physici		Mary Venditti					Month	Day	Yeer 2005	A.A
	/Medic Examin		4a. Facility Name (If not institution			4b. City, Town, or	Location of De	April ath	8 4c. C	County of Deatl	3:35P M
100	LAGITIII	Çı	Montgomery Ge	noral Hognit	a.1	Olnov			Mar	n t a am a s	
	Funeral		5. Social Security Number	6. Sex 7. Ag	e (in yrs. last birthday	Olney	If Under 24 H		h	ntgomer 9. Birti	pplace (State or Foreign untry)
ı.	Director		117-16-8973	1□M 2√2 F	79 Yrs.	Months Days	Hours Mi	Nov. 6			
	pu >		Usual Residence of Decedent  10a. State 10b. Count		10c. City, Town or L	agetian					10d leads Challen
	shov	7		ı							10d. Inside City Limits t ☐ Yes 2y No
	he M	Directo	Maryland Mont  10e. Street and Number	gomery	Rockvi1	10f. Zip Code			10= Citi-		
	a or	늅		-						en of What Co	untry ?
	eath	Funerai	14913 Waterwa	12. Was Decedent	Ever in U.S. 13		20853	(Specify Ves or No-		SA 4. Race - Amer	ican Indian
10	fter d	Fun	1 ☐ Never Married 2 ☑ Ma	Armed Forces?	No.	Was Decedent of Hi If Yes, specify Cuba	n, Mexican, Pu	erto Rican, etc.)		Black, White	
2	urs a	þ	3 ☐ Widowed 4 ☐ Divorce	If Yes, Give		1 ☐ Yes 2 ☑ No	Specify:		S	Specify:	White
21215-0036	72 ho	ted		nt's Education est grade completed)	16a. Dece	edent's Usual Occupa kind of work done of	ation	nokina	16b. Kind	d of Business/l	
2	Med Wed	npie	Elementary/Secondary (0-12)	College (1-4or 5	life.	DO NOT use retired	)	orking			
	filed within 72 hours after death with the Maryland Hygiene. ther then "natural", or flems 23a or 28a-1 show ther then "natural", or flems 23a or 28a-1 show ont, the Medical Examinar must be rightlisd at	Completed		3	Regis	tered Nur				alth Ca	re
<u>n</u>	tal Hid oth	Be	17. Father's Name (First, Middle	, Last)			18. Mother's N	ame (First, Middle,	Maiden S	iumame)	
<u> </u>	ould I Men varke vatic	2		litti	1		Rosa				
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: if item 27 is marked other than "natural", or filems 23a or 28a-f show any riburg or other treumatic event, the Medical Examination and be notified at ODGs.		19a. Informant's Name/Relation			ing Address (Street a					
	1 and Healt em 2		John Herlihy, 20a. Method of Disposition	Jr. Husba	20b. Place of Disp			Rockvil Date		ary Land ation - City or 1	
Baltimore,	ages intof intof oro		1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (		Gate of	matory or other place Heaven	1				
Ħ	artme orten injuri		21. Signatur Fugeral Service		1 2	Cemeter  2. Name and Addres	y Apr	.12,2005_	Silve	er Spri	ng,Maryland
Ba	Per Imp any		> /delent/	7/11.	Fr	ancis J.	Collins	Funeral	Home	Inc.	MD 20001
			23a. Part1. Boter the disease, of shock, or heart failure. Lis	or complications that caused	the death. Do not er	00 Univer	g, such as cardi	ac or respiratory an	rest,	Spring	Approximate
	Pnysician		Immediate Cause (Final	t only one cause on each in		RENAL					Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	a	a consequence of):		, _ , _				3 10.00
	Examiner		Cognostially list conditions	b							
	D #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying		a consequence of):					13	
	ecute and -trans	Examiner	Cause (Disease or Injury that initiated events resulting in death) Last	c							
8760,	ate be executed hysician and the burial-transit	ai E		Due to (or as	a consequence of):						
	he ye	dicai		d							
9 X	death certifica attending ph d for use as th	/Me	IF FEMALE:	23c. If yes, outcome	of pregnancy				23	d. Date of deli	ven.
Вох	atter	ciar	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 4 ☐ Pregnant at		□Ectopic pregnancy □ Other (specify)			20	Month	Day Year
o.	it the death cer by the attendir tached for use	Physician/Me	9 Unknown	9□ Unknown							
s, D	The law requires that the ite has been signed by the bage 2 should be detache	by P	Part II. Other significant condit	ions contributing to death b	ut not resulting in the	underlying cause give	en in Part I.	23e. Did to	bacco use	e contribute to	the cause of death?
ğ	v require been sig should b		MULTINIT	EM ORGAN	FAELL	-RG		. 1□Y	es 2 🗷	No 3∏Pro	bably 4 Unknown
Vital Record	e law re has be je 2 sho	Completed						24a. Was a autop	an	24b. Were aut	opsy findings available ompletion of cause of
Ě	The late happened	E O						perfor 1 ☐ Yes	med?	death? 1 ☐ Yes	
ita	icien: Th certificate rector, pag	Be (	25. Was case referred to medical examiner?					eath (Check only or			
	Physicien: r this certificant director,	ည	1 ☐ Yes 2 ☑ No		ent 2 EN/Outpatie			Home 5 Resid			ify)
Z C	iding Physicien: th. : After this certifica s funeral director, p	lon:	27. Manner of Death  1 ☑ Natural 5 ☐ Pend		ry 28b. Time ( y Year) Injury	Work	(?	28d. Describe h	ow injury	occurred	
<u>s</u>	tor the	icat	3 Suicide 6 Could		ury - At home, farm, s		/es 2 □ No	28f Location /S	treet and	Number or Ru	ral Route Number.
Division of	f or Atten after deat Director:	ertification;	4 Homicide deter	building, et	c. (Specify)	root, ractory, othoo		City or Tow			arriodo rambos,
	spite	O	29a. Certifier 1 Certify	ing Physician: To the best	of my knowledge, dea	th occurred at the tim	ie, date and pla	ce, and due to the o	ause(s) a	nd manner as	stated.
	To the Hospitel within 24 hours a To the Funerel I completely filled	Medical	(Check only 2 Medice one)	I Examiner: On the basis of and manner sta		nvestigation, in my op	oinion, death oc	curred at the time, o	date and p	lace, and due	to the cause(s)
	To the Hospitel or At within 24 hours after or To the Funerel Direct completely filled in by	N	29b. Signature and title of certifi			29c. License				signed (Month	
)	3		Broke	I when.	0	023	3630		APR.	th 8,	2005
	)		30. Name and address of person	n who completed cause of d	leath (Item 23a) (Type	Print)	RD #2	13 GAZZI	HERI	BURE.	mn 20877
	* C4	to	FRANK Is Manager 31. Date filed (Month, Day, Year				-				
	Sta Registi		APR 1 2	2005 Boxus	ar's Signature	we					

State of Maryland / Department of Health and Mental Hygiene For State Registras Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Charles April1 9, **Physician** Edward Hartman, Jr. 2005 7:45A. M /Medical 4a. Facility Name (If not institution, give street and number)
13205 Ingleside Drive 4c. County of Death 4b. City, Town, or Location of Death Examiner Prince George's Beltsville If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign
Country) Min. 1**∑**M 2□F Months Days Hours 577-26-8676 82 Yrs. October 10, 1922 Pennsylvania Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10b. County 10a State 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If them 27 is marked other than "naturat", or Items 23a or 28a-f show any injury of other traumatic event, the Medical Examinar must be notified at once. Prince George's Maryland Beltsville 1 ☐ Yes 2X No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 13205 Ingleside Drive 20705 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1X Yes 2 □ No If Yes, Give Year or Dates: 1944–1962 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian Black, White, etc. 1 Never Married Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐xNo Specify: þ Specify: White 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry United States Bureau of 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0,12) College (1-4or 5+) Printing & Engraving Plate Printer -Foreman 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Charles Edward Hartman, Sr. Loretta Campbell 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
13205 Ingleside Drive Beltsville, Maryland 20705 19a. Informant's Name/Relationship (Type, Print Rosalia D. Hartman -wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Gate of Heaven Cemetery 4/12/2005 Silver Spring, Maryland \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Donald V. Borgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland 20705 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician Coronary Artery Disease /Medical Due to (or as a consequence of): Examiner Chronic Obstructive Pulmonary Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine Physician: The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 Other (specify) P.O. I the à signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 □ No 3 □ Probably 4 □Unknown page 2 should l Be Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death? 2 □ No 1 Yes 2 🔀 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5X Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 XNo Certification: To this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Hospital or Attending 1 XNatural Injury 5 Pending after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) à 4 \ Homicide filled in 24 hours a 29a. Certifier 🔯 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2. To the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D18813 April 11, 2005 8 cause of death (Item 23a) (Type, Print) Ira Tauber, M.D. 10301 Georgia Avenue, #304 Silver Spring, Maryland 20902 31. Date filed (Month, Day, Year) APR 1 2 2005 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month

Physician
/Medical
Examiner

1 - For State Registrar

**Funeral** Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "naturel", or Items 23e or 28e-f show eny injury or other treumatic event, If a Musical Exaction rather neather an once.

Baltimore, Maryland 21215-0036

Pnysician /Medical Examiner

attending physician and for use as the burial-transit To the Hospitel or Attending Physiclen: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760. is certificate has been signed by director, page 2 should be detach After this within 24 hours after death.

MAS

State Registrar

2

Certification:

۱	Rullie Geo	orgianna	Hott							Hpril	6,	2000	5 1	6:10
	4a. Facility Name (	If not institution,	give street and nur		-4-1	4b. City,	Town, or	Location	of Death	1		County of E		/
	SACRE	D HE	FARTF	105PI		C.	4m	BE	Rh	AND	4	LLE	E C 1	any
I	5. Social Security N	Number	6. Sex	7. Age (In yrs. I		If Under Months		If Under	r 24 Hrs. Min.	8. Date of B (Month, D	rth av. Year)	9.	Birthplace Country)	(State or Foreig
	212-38-64		1 □ M 2021 F	65	Yrs.					22-Jan-		M	aryland	i
-	Usual Residence o	f Decedent 10b. County		10a Cia	, Town or Lo								1011	
	Toa. State	TOD. County												nside City Limit
	Maryland	Alleg		Moun	it Savag	e								Yes 2 N
	10e. Street and Nu	mber 16202	Callah Hill			10f. Zip	Code				10g. Citiz	en of What	t Country?	
						215	45-				U.S.A	<b>.</b>		
	11. Marital Status		12. Was Dece	edent Ever in U.	S. 13.	Was Dece	dent of H	ispanic O	rigin? (Sp	ecify Yes or N Rican, etc.)	0- 1	4. Race - A	American Ir Vhite, etc.	ndian,
ł	1 Never Man	ried 2 Marri		2 17 No		1 🗌 Yes		Specify		1110411, 0101.7			vinte, etc.	
	3 Widowed	4 Divorced	Year or D	ates:		1 1 1 1 1 1 1 1 1	2/2 110	Зреспу				Specify: <b>Wh</b>	nite	
	/Cna	15. Decedent	's Education t grade completed)		16a. Dece	dent's Usu	al Occup	ation	et of week	ina	16b. Kir	d of Busine		у
-	Elementary/Sec		College (	1-4or 5+)	life.	kind of wo DO NOT u	ise retired	d) 110:	at OF WORK	"'I'				
1	12		0		home l	nealth	care a	ide			Coun	ty Heal	lth Der	ot.
	17. Father's Name	(First, Middle, I	Last)						er's Nam	e (First, Middl				
	John E. H	arden						Maron	orat C	Wineb	annar			
ĺ	19a. Informant's N		nip (Type, Print)		19b. Maili	na Address	s (Street			al Route Num		Town Star	te. Zin Con	(a)
١	Roy E. Ho		husb	and	16202 (	-					5 40/04	200 (372)		
ŀ	20a. Method of Dis		11050		lace of Dispo					nt Savage		arylano cation - City		1545
1		•	3 Removal from		emetery, cre	matory or c	other plac	ce)						
	`4 ☐ Donation	5 Other (Sp	pecify)	Mt. Sa	avage M	ethodis	t Cem	etery	10-A	рг-2005	Mount	Savage	Maryl	and
	21. Signature of F	uneral Service I	Lîcensee	/	Colores and	2. Name ar								
-	0	huk	Alux	t	Du	rst Fu	neral :	Home,	, 57 F1	rost Ave.	, Frost	burg, N	VID 21	.532
1	23a. Part . Enter	the disease, or	complications that conly one cause on a	caused the death	n. Do not en	ter the mod	de of dyin	ng, such as	s cardiac	or respiratory	arrest,		Apr	proximate erval.Between
-	Immediate Cause	(Final	CIAI	ALL C	1-11	· n 0 ^	LUE	MA	500	C 120111	e (T	TOF		set and Death
ĺ	disease or conditi resulting in death)	on				AKC	-(NU/	-11+	471	ZNSIV	2 51	HUE	12	-/4
			Due to	(or as a consequ	uence of):								- 3	
	Sequentially list of	onditions,	b Property	Leasan	tintoni - 11	_								
	Sequentially list of cause. Enter Und Cause (Disease of	erlying	Louis to	(unas a obvised)	иатков отр									
	that initiated event resulting in death)	lS .	c											
	resulting in death)	Lasi	Due to	(or as a consequ	uence of):									
			d											
			T											
	IF FEMALE: 23b. Was deceder	nt pregnant		tcome of pregna							2	3d. Date of	delivery	
1	in the past 12	2 months?		pirth 2 Fetal		⊒Ectopic p ⊒ Other (sµ		/				Month	Day	Year
	1 ☐ Yes 2 9 ☐ Unknow		9□ Unkn			_ 0(1)01 (9)	poo.,,,							
			ons contributing to d	eath but not ree	ulting in the	inderkine r	ralise an	en in Part		23a Did	tobacco u	se contribut	te to the co	use of death?
	. are in a critic orgin		commoding to d	Call Dat HOLIGS	uning it tild t	anderlying (	wadoo yiy	√irin Fαll	**	- 10				
J										12	Yes 2	1N0 3L	] Probably	4 🗍 Unknow
										24a. Wa		24b. Wer	e autopsy f	indings availabl
										per	opsy formed?	deat	h?	tion of cause of
										I ☐ Yes	2🖾 No	1	Yes 2	IAÓ

1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner 1 Yes 2/2 No 1 🗷 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 ZNatural Injury 1 ☐ Yes 2 ☐ No investigation

2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide

29a. Certifier 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mapper stated. (Check only one) 29b. Signatu

30. Name and address of person who completed cause of death (Item 23a) (Type, F

APR 0 8 2005

QAMAR 31. Date filed (Month, Day, Year)

	_1	For State Registrer				of Mai	rylan	d / Depa <i>Cer</i>			ealth a Death	nd M	ental I		erie ) (	)5	14191	
Physicia		1. Decedent's Nam										İ	2. Date of Month	f Death	Day	Year	3. Time of Death	
/Medica	al -	ANNA	CATH			JEWE:	بليا						APR	IL :	1, 200		19:10 M	_
Examine	er	4a. Facility Name (	f not institutio	n, give :	street <b>and</b> no	umber)					Location of	Death			4c. Coun	y of Death		
		MEMORIA  5. Social Security N		6. Sex		7. Age	(In vrs. I	ast birthday)	CUN If Under	IBERI 1 Year	JAND If Under 2	4 Hrs.	8. Date o	f Birth	ALLI	EGANY 9 Bigh	place (State or Foreign	_
Funeral Director		212-12-			м <b>Ж</b> □ ғ	1	94	Yrs.	Months	Days	Hours	Min.	(Month	Day,	1910	WEST	ntry)	
		Usual Residence o											11001		1010	TILD2	7210211111	_
rytan		10a. State	10b. County					, Town or Lo									10d. Inside City Limits	
Ba-f s	cto	MD	ALL	EGAN	IY —————		CU	MBERLA	ND								1 X Yes 2 □ No	
or 2		10e. Street and Nu	mber						10f. Zip					10	g. Citizen of		ntry?	
s 23a	Funeral Director	506 WHI	TE AVE		10.111 D-			2 10 1		1502	-1.01.	-0.10-	-1		U.S.			_
item item	nue	<ol> <li>Marital Status</li> <li>Never Mari</li> </ol>	ind 2 Mar	-	12. Was De	orces?		S. 13. V	Yas Deced Yes, spec	ent of Hi	spanic Orig n, Mexican,	Puerto	Rican, etc.	r No- .)		ice - Ameri ack, White		
urs af	by	3 ₩ Widowed		1	If Yes, G Year or	2 XNo Sive Dates:	,	1	☐ Yes	2 X No	Specify:				Spec	ify: WH	ITE	
2 ho	Completed	/C	15. Deceder	nt's Edu	cation	4)		16a. Deced	ent's Usua	I Occupa	ition			1	6b. Kind of			
thin 7	ple	Elementary/Seco	c <i>ify only highe</i> ondary (0-12)	sst grade		(1-4or 5+	.)	life. L	O NOT us	se retired,	luring most	or work!	ng				NGFIELD	
ed wij	Con	8						PRODUC	TION	WOR					$\mathrm{T}^{\mathrm{IRE}}$		NY 	
be fill dott	Be	17. Father's Name CLAUDE	(First, Middle, NELSO)	,											aiden Suma	me)		
should ind Men umaric	10							1			UNA	JA		STUM				
Vical d 2 sh h and 7 is n traun		19a. Informant's N				CT BUTS	D		_						City or Town	n, State, Zi	o Code)	
is 1 and 2 of Health item 27 other tra	ļ.	ELLEN J 20a. Method of Dis		للبلة	/ DAU	GHTE		lace of Dispos			2, RII		EY, V	-	26753 Oc. Location	- City or T	own State	-
t. Pages tment of l tant: If its		1 <b>2∑</b> Surial 2	Cremation		lemoval fron	n State	0	emetery, cren	atory`or o	ther place	· 1_						D, MD	
글 교통원증		* 4 ☐ Donation 21. Signature of Fi			9.9		SOI	ISET ME			s of Facility		/ 200.		COMB	CKTWI	D, MD	
Depring Bernard Bernar		Chone	1.0	5	les h	0110	1		UPCH	JRCH	FUNE	RAL				M T	21502	
		23a. Part 1. Enter	the disease, o	r compl	ications that	caused t	he death	n. Do not ente							LAND,	M_D	Approximate	1
Prysician		Immediate Cause	art failure. Lis (Final	t only of				II 4	T2 - 43 -								Interval Between Onset and Death	ı
/Medical		disease or condition resulting in death)		-		gest. o (or as a		Heart	rallu	ire						-	l month	-
Examiner		Conventielly list or	- distant	1.	Aor	tic '	Valv	ular D	iseas	se						-	years	i
=	ner	Sequentially list of if any, leading to in cause. Enter Und	orhung	"	Due to	o (or as a	consequ	uence of):										
ecute and trans	Examiner	Cause (Disease of that initiated event resulting in death)	S		s	- /												
icate be executed physician and sthe burial-transit	<u>m</u>	resonant in acatily	2231		Due to	o (or as a	consequ	uence of):										
physi the	dlcat				d											-		
vergines that the death certific to been signed by the attending p should be detached for use as	/Me	IF FEMALE; 23b. Was deceder		2	3c. If yes, o	utcome o	f pregna	incy							234 D	ate of deliv	env	
death atter	Physiclan/M	in the past 12	months?	1		birth 2 gnant at t			Ectopic pr		.,					onth .	Day Year	
the dached	hysi	1 ☐ Yes 2 9 ☐ Unknowi			9□ Unk					,,								
The law requires that the death certif The law requires that the death certif the has been signed by the attending bage 2 should be detached for use a	by Pi	Part II. Other signi	ficant condit	ions co	ntributing to	death but	t not resi	ulting in the ur	nderlying o	ause give	en in Part I.		23e.	Did toba	acco use co	ntribute to	he cause of death?	
w requires been sign should be	leted t													1 🗌 Yes	2 <b>X</b> No	3 🗆 Pro	bably 4 □Unknown	
law re law re 2 sho	plet													Was an autopsy	246	. Were aut	opsy findings available ompletion of cause of	
	Comple													perform	ed? No	death?		
ian: artifica ctor, p	Bec	25. Was case refe examiner?	rred to medic	al							26. Place	of Death						
Physic Physic this ce ral dire	2	1 ☐ Yes 2	<b>≰</b> No	ŀ	lospital:	Inpatien	t 2 🗆	ER/Outpatien		Othe Othe	er: 4 ☐ Nur	sing Ho	me 5 🗆	Resider	nce 6 🗆 O	ther (Spec	fy)	
_ 5 9 9	on:	27. Manner of Dea 1 Natural	th 5 Pend	ing	28a. Date (Mo	e of Injury	Year)	28b. Time of Injury		8c. Injury Work			28d. Desc	ribe hov	w injury occ	urred		
Attending r death. ector: Atteby the func	cat	2 Accident 3 Suicide	inves 6 🗆 Could	tigation I not be	00- Bl-		At b		M		Yes 2□N		006 Loops	/C+-	and and \$1.00	ahadad Ou	al Cauta Number	
or A	Certification:	4  Homicide	deten	mined	286. Plac buil	ding, etc.	(Specif	ome, farm, str y)	eet, ractor	, office		1	City o	r Town,	State)	nber or Hui	al Route Number,	
spitai ours a nerai filled		29a. Certifier	1 Certify	ina Phy	sicien: To th	he hest o	f my kna	wledge, death	Occurred	at the tim	ne date and	i niace :	and due to	the car	use/s) and r	nanner as	hatata	-
e Hos 24 h e Fur etely	edical	(Check only one)			ner: On the		examina										to the cause(s)	
UNISION  To the Hospital or Attendin within 24 hours after death. To the Funeral Director: All completely filled in by the fur	Me	29b. Signature and	d title of certifi	er		/		1	29	. License	number			29	d. Date sign	ed (Month	Day, Year)	
10		1 Make	7		(/L	Spela	101 4			ח	14865			1	FPP12	- 47	T 200T	
		30. Name and add	lress of person	n who c	or pleted ca	use of de	ath (Iten	23d) (Type,	Print)	ע	1400)				٠٠٠		1 " - "	$\dashv$
カム」		BARRERA	, ROBUS	STIA	NO J	, M.I	).,	500 ME	MORIA	L AV	ENUE,	SUI	TE 2	01.	CUMBE	RLAND	, MD 21502	
Sta	8	31. Date filed (Mo	R 0. 40a	2005	Ro	Registra	r's Signa	ture ME	1									
Registr	ar	2.34	., -		-													

		For	State of Maryland / Dep		Mental Hygid	ene	11.100
		For State Registrar		ertificate of Death		g. Nro. UUJ	14136
Physici	an	Decedent's Name (First, Middle, Last			2. Date of Death Month	Day Year	3. Time of Death
/Medic	cal	Virginia Lynn K			April 9,		11:45 I
Examin	ner	4a. Facility Name (If not institution, give	·	4b. City, Town, or Location of Deat	h	4c. County of Deatl	
unaval		6600 Lake Park Dr 5. Social Security Number 6. Se		Greenbelt  y) If Under 1 Year   If Under 24 Hrs	· 8. Date of Birth	Prince G	
uneral irector			□M 2\ F 53 Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, ) July 6, 1		nplace (State or Fore untry) ginia
		Usual Residence of Decedent			July 0, 1	IJJI VII	
than "natural", or itama 23a or 28a-1 ebow the Modical Exeminer must be notified at	5	10a. State 10b. County	10c. City, Town or	Location			10d. Inside City Lim 1 X Yes 2 □ i
1-88-1	ecto	Maryland   Prince G	eorge's Greenbel				
a or	Funeral Director	10e. Street and Number	. #101	10f. Zip Code		g. Citizen of What Co	untry?
PB 23	era	6600 Lake Park Dr		20770  3 Was Decedent of Hispanic Origin? (5		J.S.A.	ncan Indian
	표	1 Never Married 2 Married	1 ☐ Yes 2 [X] No	<ol> <li>Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer</li> </ol>	to Rican, etc.)	Black, White	
e H	þ	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	1 ☐ Yes 2 💢 No Specity:		Specify: Wh	ite
ne fr	Completed	15. Decedent's Edi (Specify only highest grad	ucation 16a. Dec	cedent's Usual Occupation ve kind of work done during most of wo	rking 16	6b. Kind of Business/I	ndustry
than Le Mo	ldm	Elementary/Secondary (0-12)	College (1-4or 5+)	. DO NOT use retired)			
other t		17. Father's Name (First, Middle, Last)	4 Spe	cialist 18 Mothor's No.	me (First, Middle, Ma	FEMA	
e ve	Be	Boyd Harper Obens	hain	Marie (		alderi Sumame)	
marked matic e	2	19a. Informant's Name/Relationship (T		iling Address (Street and Number or R		City or Town, State, Z	in Code)
itam 27 ie marked othe other traumatic evant,	1 1	James Keating - H		) Lake Park Drive,			
itam 27 i		20a. Method of Disposition	20b. Place of Dis	position (Name of rematory or other place)	Date 20	Oc. Location - City or	Town, State
int: If		1 N Burial 2 □ Cremation 3 □ 1 1 Donation 5 □ Other (Specify)		Heaven Cemetery 4/	13/2005	Silver Sor	ing MD
porta y inju		21. Signature of Funeral Service Lican.	0	22. Name and Address of Facility	asch's Fu	neral Home	P.A.
important: If itam any injury or othe once.		south 11/1		4739 Baltimore Ave			20781
		23a. Part1. Enter the disease, or comp shock, or heart failure. List only	lications that caused the death. Do not e	enter the mode of dying, such as cardia	c or respiratory arres	st,	Approximate Interval Between
sician		Immediate Cause (Final disease or condition	a Multiple Myeloma				Onset and Death  1 Year
edical miner		resulting in death)	Due to (or as a consequence of):				
	-	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a consequence of):				
usit	ulu	Cause (Diseese or injury	bus to (or as a consequence of).				
al-tra	Examiner	that initiated events resulting in death) Last	C. Due to (or as a consequence of):				
nysiclen and he burial-translt	call	(	d.				
as th			Y				
attending phy I for use as the	Physician/Med	230. Was decedent pregnant	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3	B Ectopic pregnancy		23d. Date of deli	*
he att	sicia	in the past 12 months? 1 ☐ Yes 2 ☒ No		☐ Other (specify)		Month	Day Year
ed by the a	Phy	9 Unknown					
500	by	Part II. Other significant conditions co	intributing to death but not resulting in the	underlying cause given in Part I.		acco use contribute to	
been si should I	eted				T T T T T T	2 X No 3 □ Pro	obably 4 Unkno
2 0	Completed				24a. Was an autopsy performe	prior to c	topsy findings availat ompletion of cause o
icete ha						X No 1 ☐ Yes	2 No
certifical rector, p	o Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☒ No	Hospital:	Othor	ath (Check only one)		W 200 W
ar this aral di	H	27. Manner of Death	1 ☐ Inpatient 2 ☐ ER/Outpat  28a. Date of Injury 28b. Time	of 28c. Injury at	10me 5X Residen 28d. Describe how	ice 6 Other (Spec	rify)
: After s funer	atlor	1 XNatural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year) Injury	/ Work? M 1 ☐ Yes 2 ☐ No			
Director:	ifica	3 Suicide 6 Could not be	28e. Place of Injury - At home, farm,	street, factory, office		et and Number or Ru	ral Route Number,
in De	Certification:	4 nomicios	building, etc. (Specify)		City or Town,	State)	
To the Funeral Directo completely filled in by the	edical	29a. Certifier 1∑ Certifying Phy (Check only one) 2 ☐ Medical Exam	/sicien: To the best of my knowledge, de iner: On the basis of examination and/or	ath occurred at the time, date and place investigation, in my opinion, death occ	e, and due to the cau urred at the time, dat	use(s) and manner as se and place, and due	stated. to the cause(s)
the	Mec	29b. Signature and title of certifier	and manner stated.	29c. License number	290	d. Date signed (Month	, Day, Year)
0 5		DAX.		D41715		April 11,	
Con	161		1	PATITO	A	uhrrr II,	2005
2 5		30. Name and address of person who d	ompleted cause of death (Item 23a) (Tun	e. Print)			
4)		30. Name and address of person who of Chitra Venkatram	completed cause of death (Item 23a) (Typan an MD 6201 Green)	e,Print) nelt Road, Suite U	2 (211-	o Dowle Min	20740

DHMH 17 Rev 1/2001

			For State Registrer	State of Ma		epartment of F Certificate of		lental Hygiei	2000	14193
П	Physicia	an	Decedent's Name (First, Middle,     James	Last) Ervin		Voofor Ir		2. Date of Death Month	Pay Year	3. Time of Death
>	/Medic Examin		4a. Facility Name (If not institution,			Keefer, Jr.	or Location of Death	Ut (	4c. County of Dea	
	CAUTILIT		Sacred Hear	+ HOSPITO	U	cumb	criand		Allego	MY
	Funeral		5. Social Security Number 217-30-1359	4€IM 2□E	(In yrs. last birth	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye	ar) 9 Bir	thplace (State or Foreign ountry)
Ь	Director		Usual Residence of Decedent	A	70	-		03/02/1935	Mar	yland
	anylan show d at	<u></u>	10a. State 10b. County		10c. City, Town					10d. Inside City Limits 1 ☐ Yes 2 ☒ No
	the Ma 28a-f	Director	MD A11	egany		Cumberland		100	Citizen of What C	
	3a or	i Dir		d Road, N.E.		10f. Zip Code	1502	Tog.	USA	ountry?
	death	nera	11. Marital Status	12. Was Decedent E Armed Forces?	ver in U.S.	13. Was Decedent of H		ecify Yes or No-	14. Race - Am Black, Whi	
36	or ite	y Fu	1 Never Married 2 Marrie	ld 1 XYes 2 N If Yes, Give		1 ☐ Yes 2 ☐ No		rnoan, etc.)	Specify:	
00	72 hours after death with the Maryland natural; or items 23e or 28e-f show Jical Examiner must be notified at	Completed by Funeral	3 ☐ Widowed 4 ☐ Divorced  15. Decedent'	Year or Dates:	1963	ecedent's Usual Occup	pation	166	. Kind of Business	White
215	within 72 ene. than "ne tte Madie	piet	(Specify only highest Elementary/Secondary (0-12)			Give kind of work done ife. DO NOT use retire	during most of work	ing	. rung or business	a modely
21	e filed within al Hygiene. I othar than ' vant, the Wa	Con	12	1		Laborer			Tire and R	ubber
Maryland 21215-0036	rit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan artiment of Health and Mental Hydiene.  ortant: If item 27 is marked othar than "natural; or items 23a or 28a-f show injury or other traumatic event, Itte Madical Examinat must be notified at any or other traumatic event, Itte Madical Examinat must be notified at 8.	To Be	<ol> <li>Father's Name (First, Middle, L James</li> </ol>	Ervin	Keef	er, Sr.	18. Mother's Name	e (First, Middle, Maid K	12.0	Royer
aryl	2 should be and Mental is marked of raumatic ever	ĭ	19a. Informant's Name/Relationsh			Mailing Address (Street	and Number or Run	al Route Number, Ci	ty or Town, State,	
	and 2 Balth a n 27 is		Sharon F. Keefe	r /wife	1	1721 Bedford	Road, N.E.,	Cumberland,	Mary land	21502
Baltimore,	Pages 1 nent of He int: If itan		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation	3 □Removal from State	20b. Place of E cemetery,	isposition (Name of crematory or other pla	ce)		. Location - City or	Town, State
ţ	permit. Page Department of Important: If any njury or once.	. 74	* 4 ☐ Donation 5 ☐ Other (Sp 21. Signature of Juneral Service L	* *	MD Vet.	Cem @ Rocky G			Flintstone	,
Ba	Department of the services once		21. Signature of Juneral Service L	loensae	1	22. Name and Addre		, Cumberland		
			23a. Part1. Enter the disease, or shock, or heart failure. List of	complications that caused	the death. Do no					Approximate Interval Between
W	Physician		Immediate Cause (Final disease or condition			dewa				Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as	a consequence of	dema lanomo				3 mo4/15
1		er	Esquantially list conditions, if any leading to immediate	Due to (or a	consequence of	an o ma	•			- 1110475
	uted d ansit	Examiner	Esquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events							
o,	s be executed sician and burial-transit		resulting in death) Last	Due to (or as	a consequence of	):				
8760,	cate be ex ohysician the buria	dica		d						
9 x	The law requires that the death certificate be executed tee has been signed by the attending physician and tage 2 should be detached for use as the burial-transit	ician/Medical	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	of pregnancy				23d. Date of de	liveo
Box	death e atter id for u	iclar	in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant at		3 ☐ Ectopic pregnanc 5 ☐ Other (specify) _	у	·	Month	Day Year
О	that the de led by the a detached f	Physi	9 🗆 Unknown	9□ Unknown				- 1		
S	ires tha signed I be de	þ	Part II. Other significant condition	rs contributing to death by	it not resulting in 1 Luncu	he underlying cause giv	u Soli Si	23e. Did tobac	×4	o the cause of death?
Records	w requir been si should	Completed	Disemina	tel Mo	to to s		- 204	24a. Was an		
Re	The law cate has page 2	dmc	Dreak locic	of pres	To 110	tustrusico :	Dochi	autopsy performed	prior to death?	utopsy findings available completion of cause of
<u>ia</u>		BeC	5. Was cas referre in medical	ane	4 just	winds.	26. Place of Deat	1 Yes 2 X	No 1 ☐ Yes	s 2 No
of <	Physicien: this certific ral director,	ToE	examin⊶? 1 ☐ Yes 2 No	Hospital: 1 Inpatie			4   Nursing no	me 5 Residence		ecify)
	ling After une	ion:	27. Manner of Death  1 Natural 5 Pending 2 Accident investig			ury Wo	ryat rk? ]Yes 2 □ No	28d. Describe how i	njury occurred	
Division	If or Attanding after death. Diractor: After d in by the funer	fical	3 Suicide 6 Could n	ot be 28e. Place of Inju	ıry - At home, farr	n, street, factory, office	1.00 5 510	28f. Location (Stree	t and Number or R	lural Route Number,
Ö	Dir	Certification;	4 Homicide	building, etc	: (Specify)			City or Town, S	tate)	
	Hospital or 24 hours afte Funaral Dir. stely filled in I	edical	(Check only 2 Medical E	Physician: To the best of examiner: On the basis of	of my knowledge, examination and	death occurred at the ti	me, date and place, opinion, death occur	and due to the caus	e(s) and manner a and place, and du	s stated. e to the cause(s)
	To the Hos within 24 h To the Fur completely	Med	one)  29b. Signature and title of certifier	and manner eta	ted.	29c. Licens			Date signed (Mon	
L	. /			elipa	uD to	ACP DIZ	SIODI	A	il gi	ud 2001
(	TIVA		30. Name and address of person	who completed cause of d	eath (Item 23a) (T	ype, Print)	301	XIP		2001
	ARS		V.K.FE	LIPA,	MD 98	x5 Bishop	Malsh	Koad (1	umberli	and Indala
	Sta Regist		31. Date filed (Month, Day, Year) APR 0 4	2005 32 Aegistra	ar's Signature	Cook .				
		· E		-	W. C. P.	A CANONICAL CONTRACTOR				

		4	For State Registrar			d / Depa		lealth and	Mental Hyg	•	
			Decedent's Name (First, Middle	e, Last)					2. Date of Deat	h	3. Time of Death
	Physici /Medic Examin	al	LUCIEN ALEXAND  4a. Facility Name (If not institution				4b. City, Town, o	r Location of Deat	April 1		
	LAdillii	-	6145 Bumpy Oa				La P1			Charle	
	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. la	ast birthday)	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	8. Date of Birth (Month, Day,		Birthplace (State or Foreign Country)
	Director	i -	230-46-1492 Usual Residence of Decedent	<b>X</b> □M 2□F	66	Yrs.	Wienians Buys	Tiodis IVIII.	Nov 28	1938 V	irginia
	how		10a. State 10b. County		1	, Town or Lo	cation				10d. Inside City Limits
	Ba-f-s	ctor	Maryland Charl	es	La	Plata					Yes 2 No
	ith th	Director	10e. Street and Number				10f. Zip Code		1	0g. Citizen of Wha	at Country?
	s 236	rai	6145 Bumpy Oak				20646			USA	
36	nit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland artment of Health and Mental Hygiene. ortent: If item 27 is marked other than "natural", or Items 23e or 28e-f show injury or other treumatic event, the Medical Exatt inclinital and injury or expert inclinital at all and a second second.	by Funeral	11. Marital Status  1 ☐ Never Married 2 ☒ Mar  3 ☐ Widowed 4 ☐ Divorced	Armed Fo	2 □ No ve		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 🙀 No	lispanic Origin? (S an, Mexican, Puer Specify:	ipecify Yes or No- to Rican, etc.)		American Indian, White, etc. White
21215-0036	in 72 hou n "natura Aedical E	Completed by		it's Education st grade completed)	1.42.5.)	16a. Dece (Give life.	dent's Usual Occup kind of work done DO NOT use retired	ation during most of wo	rking	16b. Kind of Busin	ness/Industry
212	2 should be filed within and Mental Hygiene. Is marked other than "eumatic event, the Mec	mo;	1 1	College (	1-401 5+)	Se1	f employ	ed		General	Handy Man
	be file tal Hy d othe	Be C	17. Father's Name (First, Middle,	Last)				18. Mother's Na	me (First, Middle, I		
<u>la</u> i	Ments Ments arked	10.	Lucien Larkin					Robert	a B. Lark	in	
Maryland	2 sho and l is mu		19a. Informant's Name/Relations	thip (Type, Print)		19b. Maili	ng Address (Street	and Number or Re	ural Route Number	, City or Town, Sta	ate, Zip Code)
	of Health of Health litem 27 i		Georgianna Lar	kin (wife		6145	Bundy O	ak Road I	la Plata,		
ore	or oth		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation	3 □Removal from	1 00	ace of Dispo emetery, crei	sition (Name of matory or other plac	се)	Date	20c. Location - Cit	ty or Town, State
Ë	ment tent: jury		`4 □Dohation 5 □ Other (S		Met		tan Crem		12-05	Alexandr	ia, VA
Baltimore,	permit. Page Department o Importent: If any injury or once.		21. Signature of Fune at Service	Licensee	100173	123	2. Name and Addre	E	berwein F . White F		
	EL TO		23a. Party Enter the disease, o	r complications that	caused the death						Approximate Interval Between
	Physician		Immediate Cause (Final ase or condition	R	21/20	(	mce	1			Onset and Death
	/Medical		resulting in death)	a. Due to	(or as a consequ						-
ю	Examiner		Soquestially list conditions	b							
-	p #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying		(or as a consequ	ence of):					
	be executed sician and burial-transit	Examiner	that initiated events resulting in death) Last	c							
760,	tte be execut tysician and ne burial-tran	ũ	resulting in death) cast	Due to	(or as a consequ	Jence of):					
876	a X	dicai		d							
x 68	eath certifical attending phy for use as th	Physician/Med	IF FEMALE:	23c If yes ou	tcome of pregna	ncu/					
Вох	atter for u	ian	23b. Was decedent pregnant in the past 12 months?	1 Live	birth 2 ☐ Fetal	death 3	Ectopic pregnancy Other (specify)	/		23d. Date of Month	•
Ö	0 0	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unkr		edui 5					
م.	requires that the een signed by th nould be detache		Part II. Other significant conditi	ons contributing to d	leath but not resu	alting in the u	inderlying cause giv	ren in Part I.	23e. Did tol	acco use contribu	ute to the cause of death?
Records,	luires n sigr	d by							1 □ Ye	s 2 □ No 3	Probably Unknown
Ö	- 0.76	iete							24a. Was a	n 24b. We	re autopsy findings available
Re	0 L 0	ompieted							autops	y prio ned? dea	or to completion of cause of the third in the cause of th
Viital	sicien: Th certificate rector, pag	e C	25. Was case referred to medica	u				26 Place of De	ath (Check only on	7	Yes 2□ No
>	S S D	0	examiner? 1 ☐ Yes 2 No	Hospital:	Inpatient 2	ER/Outpatie	nt 3 DOA Oth	AC	Home 5 Veside		(Specify)
ιof	ding Ph h. After th funeral	L:u	27. Manner of Death	28a. Date	of Injury oth, Day Year)	28b. Time o	f 28c. Injui	y at		ow injury occurred	
<u>i</u>	Attending r death. ector: After by the funer	atio	- C . losidom	igation	,,	,,		Yes 2 □ No			
Division	r Atte	tific	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide detern	nined 286. Plac	e of Injury - At ho	me, farm, st	reet, factory, office		28f. Location (Si City or Town		or Rural Route Number,
	itel o irs aft rel Di led in	Certification;									
	To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu	edical		ng Physician: To th Examiner: On the l and mar							er as stated. d due to the cause(s)
	Vithin Fo th compl	Me	29b. Signature and title of certific	er	۱ . ۵۱	<u> </u>	29c. Licens	se number	2	9d. Date signed (/	Month, Day, Year)
			1 poul	- M	Meet	tin	DJ	£35		4-14	-05
()			30. Name and address of person	who completed cau	se of death (Item	1 23a) (Type	Print)		A - A	1	1101
1	B		10 150	x 1-	703		10/1	cfc	1~~7	20	646
	Sta Regist	ate rar	31. Date filed (Month, Day, Year APR 1	4 2005	Registrar's Signa	ture	belle	-			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Year **Physician** 7:17 PM April 7,2005 Fred Harold Lewis /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Washington County Hospital Hagerstown Washington If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1∭M 2□F 81 Yrs. Director January 2, 196-14-8277 Usual Residence of Decedent the Maryland 10c, City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f shov other treumatic event, the Mydical Expirator must be notified at 1X Yes 2 □ No Director MD Washington Hagerstown 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code permit. Pages 1 and 2 should be filed within 72 hours efter death with Department of Health and Mental Hygiene. important: if them 27 is marked other than "--- any injury or other treumer!-USA Completed by Funeral 1210 West Washington Street 21740 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: 3 ☐ Widowed 4 X Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Consulting Engineer Highway Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be John Frank Lewis Georgia Etta Mellott 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia J. Newlin/Daughter P.O.Box 138 Falling Waters, WV 23419 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Cedar Grove Cemetery 04/20/05 Warfordsburg, PA 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Juneral Service Linux 22. Name and Address of Facility 141 West Main Street Grove Funeral Home, P.A. Hancock, MD 21750-0368 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Pneumonia Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of). er Tension **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Physician/Medical Examiner anding physician and use as the burial-transit Hospitel or Attending Physicien: The law requires that the death certificate be executed 2 min An Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) P.O. 9☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 ØUnknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 2 2 No 1 🗌 Yes director, 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1. Inpatient Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 5 Pending investigation 1 Natural after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ģ determined 4 🗌 Homicide filled within 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 00060396 8 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1126 1010 3 MURSHED

State

Registrar

FARIN

31. Date filed (Month, Day, Year)

2005

Hagers

no

egistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 200 tate of Manyland Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 1 - For State Registra 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day Year Harry Edward Marts April 12 2005 /Medical 11:00 A 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner 1015 Jubilee Way Waldorf Charles If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral**  Birthplace (State or Foreign Country) XM 2□ F 58 Director 316-44-3943 OCT 24 1946 Indiana Usual Residence of Decedent death with the Maryland 10b. County 28a-f show 10c. City, Town or Location 10d. Inside City Limits ns 23a or 28a-f shov Completed by Funeral Director 1 ☐ Yes 2 ☐ No Maryland Charles Waldorf 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1015 Jubilee Way 20602 USA 11. Marital Status Was Decedent Ever in U.S. Amed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, the Medical Examiner Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 to Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ō 1 ☐ Yes 2√2 No Specify: Specify: White 3 ☐ Widowed 4 ← Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry other then Elementary/Secondary (0-12) College (1-4or 5+) Guard Security ith and Mental Hygin 27 is marked other r traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Harry Marts ၉ Ruby A. Lord 19a. Informani's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 i 2101 West Key St Colton, California ce of Disposition (Name of Date 20c. Locatio other Larry A. Lord (Brother) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ By 1 2 文 Cremation 3 ☐ Removal from State
4 ☐ Fonation 5 ☐ Other (Specify) to = 5 permit. Page Department of Important: If any injury or once. Metropolitan Crematory 04/14/05 Alexandria, VA 22. Name and Address of Facility Eberwein Funeral Services of Feneral Septice Licensee 21. Sign Mu! 4433 White Pls. La. White Pls., MD 20695 m1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, lock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Distay Heart LSchemic /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine Attanding Physician: The law requires that the death certificate be executed burial-transil Due to (or as a consequence of): CHARLES CO. 2005 Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? s been signed should be d Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has funeral director, page 2 autopsy performed? certificate 2 No 1 Yes 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Presidence 6 Other (Specify) 1 Kes 2 No Certification: To 27. Manner of Death 28c. Injury al Work? 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred Director: After 14 Natural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident in by the 6 Could not be delemined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide ö within 24 hours a To the Funeral C 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the lime, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Jahin M. Tagouri un 00050883 4/12/05 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NO 20646 PL 11655 WINESap 31. Date filed (Month, Day Year) APR 1 4 2005 32. Registrar's Signature of Sparker State Registrar

			1 - For State Registrar	State of Ma	ıryland ,	/ Depa <i>Cer</i>	rtmen	t of H e of L	ealth and Death	d Men		ne O	5	4197	
	Physici /Medic		1. Decedent's Name (First, Middle, Douglas	William	Mil:	roy				l N	Date of Death Month	Day 7, 2	Year 005	3. Time of Death 8:15a	_
	Examin		4a. Facility Name (If not institution, Southern Mar	yland Hosp				int	Location of De	eath		4c. County	of Death ce G	eorges	_
	Funeral Director		5. Social Security Number  015-42-7814 Usual Residence of Decedent	6. Sex 7. Age	(In yrs. last	Yrs.	Months	Days	Hours M	lin. (/	Date of Birth Month, Day, Y	,195	9. Birthp Coun 2	lace (State or Foreign try) MA	-
	ne Maryłan 8a-f show otified at	ector		rles	10c. City, T	aldo:	rf							0d. Inside City Limits 1 ☐ Yes 2 🛣No	
	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or Iteme 23a or 28a-f show or other traumatic event, the Medical Examinar must be notified at	by Funeral Director	10e. Street and Number  931 Barringt  11. Marital Status	12. Was Decedent E	ver in U.S.	13. W		206	02 spanic Origin? n, Mexican, Pu	(Specify			Vhat Coun SA e - Americ		
0036	nours after ural', or Ite	d by Fur	1 Never Married Married 3 Widowed 4 Divorced	Year or Dates:		1	□ Yes 2	No No	Specify:	ierto Ricar	n, etc.)	Specify	k, White, o	ite	
Baltimore, Maryland 21215-0036	s within 72 h plene. r than "nat	Completed	15. Decedent' (Specify only highest Elementary/Secondary (0-12)			life. D	ent's Usua kind of wor PO NOT us S i C i	k done d e retired)	uring most of v			b. Kind of Bu	edic		
yland ;	ould be filed Mental Hyg arked othe	To Be C	17. Father's Name (First, Middle, L Finlay C. M	ilroy					18. Mother's Murie	1 1	M. McC	Combe			
e, Mar	1 and 2 sho Health and em 27 is m ther traum		19a. Informant's Name/Relationsh Peggy Milroy/ 20a. Method of Disposition	· · ·			Bar	ring	nd Number or Ston I		Waldon		20	602	_
altimor	t. Partmer		1 Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp  21. Signature of Funeral Service L		Mary	etery, crem y 1an	atory or of d Ve	ther place tera	ans 4/		05 Cł	nelte	nham	,MD	
ä	permi Depa Impo any ir		23a. Pan1. Enter the disease, or o shock, or heart failure. List of	complications that caused inly one cause on each lin	the death. [	Do not ente	P.O.	BOX e of dying	s of Facility -ECHOL K 567, g, such as card	LA LA diac or res	JNE KAI PLATA piratory arrest	, MD	206	Approximate Interval Between	
	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a	tic ] consequencer Cir	ce of):		opat	thy					Onset and Death	_
8760,	icate be executed physicien and s the burial-transit	icai Examiner	Sequentially list conditions, in the conditions, in the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to lor as a c. Due to (or as a d.	consiguen	ce di):									
P.O. Box 68	ath certif attending for use a	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at 9 □ Unknown	2 Fetal de	ath 3 🗆	Ectopic pre Other (spe					23d. Dat Mor	e of delive	ry Day Year	
Ś	w requires that the de been signed by the a should be detached (		Part II. Other significant condition Acute Renal		t not resultin	ig in the un	derlying ca	ause give	n in Part I.	_		_	ibute to the	e cause of death?	
II Reco	The taw re cate has be page 2 sho	Completed by	Cardio Respi	ratory Arr	est					-	24a. Was an autopsy performe	d? p	Vere autoperior to content of the co	esy findings available appletion of cause of	
Division of Vital Record	Attending Physician: The tar death. sr death. sector; After this certificate ha by the funeral director, page.	To Be	25. Was case referred to medical examiner?  1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending investigs		281	Outpatient b. Time of Injury		Bc. Injury Work	26. Place of Dr. 4 Nursing at ?	g Home					
Divisi		Certification:	3 Suicide 6 Could no 4 Homicide determin	ot be		, farm, stre	et, factory,			28f. L	ocation (Stree lity or Town, S	et and Numbe State)	er or Rural	Route Number,	
	To the Hoepital or within 24 hours after To the Funeral Discompletely filled in	Medicai	(Check only 2 Medical E	Physician: To the best o xaminer: On the basis of and manner stat	examination	dge, death and/or inv	estigation,	in my op	inion, death oc	ace, and d courred at	the time, date	and place, a	and due to	the cause(s)	
^	To Vit	F.	29b. Signature and title of certifier  30. Name and address of person w	11. m	D	(a) (T::		D198				Date signed	•		
+	D 151	te_	Jaime Botell 31. Date filed (Month, Day, Year)	o, M.D. 132	8 Sou	uthe:	rn A		SE, W	lashi	ingtor	DC 2	2003	2	
	Registr	ar	APR 14	2005	w do	X A	rede	0							

		1 - For State of Maryland / Dep Registrar Ce	ertment of Health and lertificate of Death		iene 005	14198
	, iii	Decedent's Name (First, Middle, Last)		2. Date of Death	h	3. Time of Death
Physic /Medi		Anderson C. Moore		April	9 2005	6:00 P M
Exami		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	h	4c. County of Dea	
		Forestville Health & Rehab. Ctr.	Forestville	2	Prince	e George's
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.		Year) 9. Bi	rthplace (State or Foreign country)
Director		073-20-5850		Aug. 29,		lew York
pue ≱		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or L	ocation			10d. Inside City Limits
haryli sho	5					1 X Yes 2 □ No
the N	Director	Maryland Prince George's	Ft. Washington		Og. Citizen of What C	
with						
leath	Funerai	6801 Bock Rd., #310  11. Marital Status 12. Was Decedent Ever in U.S. 13.	Was Decedent of Hispanic Origin? (S		United 14. Race - Am	
fter of	듄	Armed Forces?  1 Never Married 2 Married 1 Yes 2 No	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert	o Rican, etc.)	Black, Whi	
rocc after death with the Marylan ral', or Itams 23a or 28a-f show	by	3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☐ No Specify:		Specify: B	lack
72 ho	Completed	15. Decedent's Education 16a. Dece (Specify only highest grade completed) (Giv.	edent's Usual Occupation	1	16b. Kind of Business	s/Industry
B	pie	Elementary/Secondary (0-12) College (1-4or 5+)	e kind of work done during most of wor DO NOT use retired)	rking	Con Edi	.son
arth	lo G	7th	Steamer Repairma	n	N.Y. (Sub	way System)
be filed within 72 hours after dea tial Hygiene. of other than "natural", or Itams event, Ita Medical Eraniner in	Be	17. Father's Name (First, Middle, Last)	18. Mother's Nar	me (First, Middle, M	faiden Surname)	
2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or Itams 23a or 28a-f show surmatic event, the Medical Exact and retrivative recitive and	2	Norvel J. Moore			Augusta	
and and ls m			ing Address (Street and Number or Ru			
and and ealth m 27			1 Bock Rd., #310	-		20744
permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: if Itam 27 is marked other than any joury or other traumatic event, Itam 2008.		20a. Method of Disposition 20b. Place of Disposition 1 Burial 2 Cremation 3 Removal from State	ematory or other placer k	Date 2	20c. Location - City or	r Town, State
. Pag Imen Itant: jury		`4 □Donation 5 □Other (Specify) Maryland	National Mem. 4/	13/2005	Laure	1, MD
permit. Departn Imports any inju		21. Signature of Funeral Service Licensee			Funeral Ho	me
4 00 F 8 0		John 1. Sleday III	4001 Benning Rd.			20019
		23a. Part1. Enter the disease, or complications that caused the leath. Do not en shock, or near failure. List only one cause on each line.	nter the mode of dying, such as cardiac	or respiratory arre	st,	Approximate Interval Between
Physician		Immediate Caule (Final disease or condition Stroke				Onset and Death
/Medical Examiner		resulting in death)  Due to (or as a consequence of):				
LAdiffiles	l,	Sequentially list conditions, b. End Stage Deme	ntia			
sit sit	Examiner	f any, leading to immediate cause. Enter Underlying Cause (Disease or noun)				
ecut and I-tran	хап	Cancer of Pros resulting in death) Last  Cancer of Pros Due to (or as a consequence of):	tate			
The law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the burial-transit						
phys the	dicai	d				
Se as	cian/Me	IF FEMALE: 23c. If yes, outcome of pregnancy				
atten for u	ian	in the past 12 months?	☐Ectopic pregnancy ☐ Other (specify)		23d. Date of de Month	Day Year
the d	hyslo	1 L Yes 2 No 9 Unknown				
res that the death certificate by the attending be detached for use as	10	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tob	acco use contribute t	to the cause of death?
sign of be	d by			1 ☐ Yes	s 2□No 3□P	robably 4 ⊠Unknown
w require been si should?	Completed			245 1455 55	0.45 245	dans Cadana da Laba
he fav	m d			24a. Was an autopsy perform	prior to	utopsy findings available completion of cause of
				1 Yes 2	XXNo 1 ☐ Yes	s 2 No
Attanding Physician: or death. sctor: After this certifica	o Be	25. Was case referred to medical examiner?  Hospital:	Othor	ath (Check only one	1	
Phy rathis	I	1 ☐ Yes 2 2 KNo	THE SEL DOA 4 A INUISING H	lome 5 ☐ Resider 28d. Describe how	nce 6 Other (Spe	ecify)
ding Ph th. After th funeral	tion	1 X Natural 5 □ Pending (Month, Day Year) Injury 2 □ Accident investigation	Work? M 1 ☐ Yes 2 ☐ No			
Attand death ctor: y the	Certification;	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, si		28f. Location (Str.	reet and Number or R	iural Route Number.
after after d in b	erti	4 Homicide determined building, etc. (Specify)		City or Town,		
spita nours naral		29a. Certifier 1 Certifying Physician: To the best of my knowledge, dea	th occurred at the time, date and place	, and due to the car	use(s) and manner a	s stated.
o the Hospital or vithin 24 hours afte o the Funeral Dir ompletely filled in	Medical	(Check only one) 2 Medicel Exeminer: On the basis of examination and/or in and manner stated.	nvestigation, in my opinion, death occu	rred at the time, da	te and place, and du	e to the cause(s)
To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the th	Me	29b. Signature and title of certifier	29c. License number	29	d. Date signed (Mon	th, Day, Year)
1-320		· GVVVVV	D 51520		04-12-	05
(1)		30. Name and address of person who completed cause of death (Item 23a) (Type	, Print)			
(04)			outhern Ave., S.E.	#310 Wa	sh. DC 2	0032
St	ate	31. Date filed (Month, Day, Year)		" DIO WO	DILO DO Z	0024
Regist	rar	APR 1 3 2005	4			

DHMH 17 Rev 1/2001

			1 - For State Registrar	State of M	aryland			of Health a		ental Hy	/gien	11115	14199
			1. Decedent's Name (First, Middle, L.	ast)					2	2. Date of D			3. Time of Death
н	Physici		Carrie Beli	1	Mayo				Δ.	Month pril	10 Da	2005 Year	
	/Medi		4a. Facility Name (If not institution, gi				Ab City Tou	m as I applies a		hrrr			5:35am M
	Examir	ner					4D. City, Tow	m, or Location o	or Death		40	c. County of Death	
			SOUTHERN MARYLA					CLINTON	04 1/00			PRINCE	
	Funeral			Sex 7.Ag 1 □ M XXXF	ge (In yrs. last		If Under 1 Y	ear If Under 2 ays Hours	Min.	B. Date of Bi (Month, D	rth ay, Year	9. Birth	place (State or Foreign untry)
	Director		225 44 8208		84	Yrs.			J	JUN. O	8, 1		RGINIA
	and *		Usual Residence of Decedent  10a. State 10b. County		10c. City, T	own or Lo	cation						10d Jasida Ciby Limite
	laryl sho	5	·										10d. Inside City Limits XIX Yes 2 □ No
	Ne N	Director		GEORGES	CLI	NTON							V.V. 162 5 □ 140
	ith t	i	10e. Street and Number				10f. Zip Coo	de			10g. Ci	tizen of What Cou	intry?
	ath v 238		9211 STUART LANE					2073	35		1	UNITED S	TATES
	em s	Funeral	11. Marital Status	12. Was Decedent Armed Forces	Ever in U.S.	13. V	Vas Decedent Yes, specify (	of Hispanic Orig Cuban, Mexican,	gin? (Speci	fy Yes or No	0-	14. Race - Amer Black, White	ican Indian,
9	afte or it		1 Never Married 2 Married	1 □Yes XX If Yes, Give		i	□ Yes XX						
g	hours after death with the Maryland turel', or items 23a or 28a-f show of Example of must be codified at	d by	XX Widowed 4 □ Divorced	Year or Dates:				Opecity.				Specify: BL	ACK
21215-0036	72 na	ete	15. Decedent's E (Specify only highest gr		1	6a. Deced	ent's Usual Ockind of work do	cupation	t of working	,	16b. K	(ind of Business/li	ndustry
21	within ene. then "	npi	Elementary/Secondary (0-12)	College (1-4or	5+)	life. D	O NOT use re	one during most stired)	or working	1			
7	filed w Hygier other th	Completed	8TH			HOM	EMAKER				]	DOMESTIC	
B		Be	17. Father's Name (First, Middle, Las	t)				18. Mother	r's Name (I	First, Middle	, Maider	Sumame)	-
<u>a</u>	uld be Mental rrked c	To	GEORGE HICKS					LUET	TTA Y	ANCEY			
Maryland	2 should be and Mental is marked aumatic ev		19a. Informant's Name/Relationship	(Type, Print)	1	19b. Mailin	g Address (Str				er, City	or Town, State, Zi	p Code)
	12 and		SYLVIA D. BOYD /	DAUGHTER		1713	I. ST.	NORTHEA	AST T	JACHTN	JCTO	N, DC 200	nn 2
Baltimore,	- I m =		20a. Method of Disposition	DITOUTEDA	20b. Place	e of Dispos	ition (Name o	f	Dat			ocation - City or T	
2			Burial 2 Cremation 3				atory or other		01/11	10005			
₫	그 된 본 중 .		<ul> <li>4 □Donation 5 □ Other (Special Signature of Funeral Service Lice</li> </ul>		ROCKY	MT.	BAP. C	HURCH	U4/16	72005	SK	IPWITH,	VA
Ba	permi Depa impo any ir		21. Signature of Puneral Service Lice	1 /2	bas							neral Ho	
	402,44		- Manuary C	X. I SICX	161			tland Ro				MD 2074	6
			23a. Part1. Enter the disease, or con shock, or heart failure. List only	plications that cause one cause on each l	d the death. [ ine.	Do not ente	r the mode of	dying, such as c	cardiac or r	espiratory a	ırrest,		Approximate Interval Between
	Ph <sub>_</sub> sician		Immediate Cause (Final disease or condition	Seps	Sis							1	Onset and Death
	/Medical		resulting in death)	Due to or as	a consequen	ce of):							
	Examiner		One of the state o		ral	dew	Ubitus	· ulce vention	Y			1	
		Je.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequen	ce of):	1	4					
	uled d arisit	Ē	Cause (Disease or injury that initiated events	1713	heir	ner	s de	rentic	1				
Ć.	n en ial-tr	Examine	resulting in death) Last	C. Due to (or 15	a consequen								
8760,	eath certificate be executed attending physicien end for use as the burial-transit		· ·	Dial	setec	Me	llitus					1	
687	ficate phy s the	Physician/Medical	333	0.			VĮ , -						
	certificanding plans as t	/Me	IF FEMALE:	23c. If yes, outcome	of pregnancy								
Вох	death e atten ed for u	lan	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant a	2 Fetal dea	ath 3 🗆	Ectopic pregna					23d. Date of delive Month	ery Day Year
o.	D 0 D	ysic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	9□ Unknown	t time or death	1 5	Other (specify	7					-,
۵.	that the death cert ed by the attendin detached for use	Ph	Part II. Other significant conditions	contribution to double		- in the court				00- Bill			
ŝ	w requires that the s been signed by th should be detache	Completed by	artin other significant conditions	A la - (> A	() -			given in Part I.				_	he cause of death?
orc	inpe sen s bluo	ted	Coronary	My tery	1139	eas (				1 🗆	Yes 2	□ No 3 □ Prob	bably 4 Unknown
Vital Record	> 40	ple								24a. Was		24b. Were auto	ppsy findings available
ď	The faw ite has b bage 2 st	E O									rmed?	death?	mpletion of cause of
ta	an: tifica tor, p	e e	25. Was case referred to medical					26 Place	of Death (C	1 □ Yes Check only o	26 No	1 ☐ Yes	2 No
>	Physician: this certific ral director,	To B	examiner? 1 ☐ Yes 2 <b>2</b> No	Hospital:	2 2 ED/	Outpatient	3□ DOA	0.1				. To:: 10	
of	r thi		27. Manner of Death	28a. Date of Inju	ry 28t	b. Time of				d. Describe I		6 ☐Other (Specif	у)
On	ding h. Afte fune	tlor	1 Natural 5 Pending investigatio	(Month, Da	y Year)	Injury		njuryat Work? □ Yes 2 □ N			non injur	y 333311733	
S	deal deal ctor: / the	ca	3 ☐ Suicide 6 ☐ Could not b	e and Class of Ini	un. At home	farm etro				Longtion /	Ctoodo	41	10
Division	or A after Dire	ertification:	4 Homicide determined	building, et	c. (Specify)	, 16/111, 5(16)	et, factory, offi	Ce .	201.	City or To	wn, State	d Number or Rura )	II Moute Number,
_	To the Hospital or Attending Physician: The lav Within 24 burus after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	0	00-0-4		2 1 1								
	Hos 24 hc Fun Fun	edical	(Check only 2   Medical Exal	nysician: To the best miner: On the basis o	t examination	and/or inve	occurred at the estigation, in m	e time, date and ny opinion, death	l place, and h occurred :	I due to the at the time,	cause(s) date and	and manner as s place, and due to	tated. the cause(s)
	To the within 2 To the complet	Med	0,10)	and manner st	ated.								
	T wit		29b. Signature and title of certifier		43			ense number			29d. Dai	te signed (Month,	Day, Year)
,			9 22			numi	) DOG	053219	7		4/1	1/2005	
2	(4)		30. Name and address of person who	completed cause of o	leath (Item 23)	a) (Type, P	'rint)	0 1	1	, 1	1		
			CAFAR A. ANS	ARIMI	TEPO	OST (	Office	Road	Wa	der-	1 ch	11) 201	502
	Sta	te	31. Date filed (Month, Day, Year)	. Registr	ar's Signature	1	<b>.</b>	(					
	Registr	ar	APR 1 3 200	Bloom	15	Apres.							

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 14200 Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** MILDRED LOUISE 8, April 2005 9:58A. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Holy Cross Hospital Silver Spring Montgomery If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Min Hours 1 M 2 TF 73 June 10, 1931 Kentucky 578-42-3592 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland worls 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heatth and Mental Hygiene. Importent: If igen 27 is marked other then "naturel", or items 23a or 28a-1 show any injury of other treumatic event, it a Madical Examiner must be natified at a Maryland Montgomery Silver Spring Director 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 14912 Claude Lane 20905 United States Funeral Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2X Married ☐Yes 2 XNo Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White ð 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Bookkeeper Concrete Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Walter Clara Stock Schmidt ္ရ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14912 Claude Lane Silver Spring, Maryland 20905 Fred W. Maier -husband 20a. Method of Disposition
1 □ Burial 2 △ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Metropolitan Crematory 4/9/2005 Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Liçensee 22. Name and Address of Facility Donald V. Borowardt Funeral Home, PA any it 4400 Powder Mill Road Beltsville, Maryland 20705 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Arteriosclerotic Cardiovascular Disease /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine attending physicien and for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medicai IF FEMALE. 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 Ø No Month Year Day P.O. F 4☐Pregnant at time of death 5 Other (specify) ed by the a detached f 9 Unknown 9 Unknown s been signed b should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. Completed by Lyme Disease 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? cate has page 2 autopsy performed certificate 1 ☐ Yes 2X No 2□ No Hospital or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 9 1 ☐ Yes 2 🗶 No 1 Inpatient 2 EP/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) After th 27. Manner of Death 1 Natural 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 5 Pending death. М 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) þ determined 4 Thomicide within 24 hours a 12 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier To the ! 29b. Signature and the of certifier 0 29c. License number 29d. Date signed (Month, Day, Year) 04-08-2005 D 24348 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Steven Gruffermen My 1500 For Mg 1500 Forest Glen Rd. Silver Spring, Maryland 20910 ermon Steven 31. Date filed (Month, Day, Year) APR 12 Registrar's Signature State 2005 Registrar

			For State Registrar	State of Maryland		ment of He icate of D			iene 005	14201
	Physici /Medio Examin	al .	Dorothy Christin     Anne (First, Middle, Last     Dorothy Christin     Anne (If not institution, give	e Meyers	41	o. City, Town, or I	Location of Death		Day Year  0 2005  4c. County of Dear	3. Time of Death  12:00 Noon
	Funeral Director		Suburban Hospita 5. Social Security Number 6. Security Number 578-22-7293			Betheso Under 1 Year onths Days	la If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, March 1,	Year) Co	mery thplace (State or Foreign buntry) hington, D.C.
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "netural", or items 23e or 28e-f show any injury or other traumatic event. I'm Medical Examinant in Item Littling at Once.	af Director	10a. State 10b. County  Maryland Montgom 10e. Street and Number  11908 Georgia Ave	ery		Spring 10f. Zip Code	20902	10	og. Citizen of What Co	10d. Inside City Limits 1 □ Yes 2 ☑ No puntry?
5-0036	nours after dea urai', or items il Exambre mi	d by Funeral	11. Marital Status  1 □ Never Married 2 □ Married 3 □ Widowed 4 🖾 Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 □ Yes 2 ☒ No If Yes, Give Year or Dates:	1 🗆	Decedent of His as, specify Cuban Yes 2☑ No	panic Origin? (Sp., Mexican, Puerto Specify:	pecify Yes or No- o Rican, etc.)	14. Race - Ame Black, Whit Specify:	
121215-	iled within 72 h dygiene. ther than "netu nt, I'm Medica	Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12)	le completed)	(Give kind life. DO	noTuse retired) ry to th of Tre	uring most of work ne Secret easury	tarv	Sederal Gov	•
Maryland	12 should be f h and Mental f 7 is marked of raumatic eve	To Be	John H. Bloss,	ype, Print)		ddress (Street ar	Dorotl nd Number or Ru	ny Rob ral Route Number,	,	Zip Code)
Baltimore, 1	it. Pages 1 and intment of Health intment of Health international intern		James H. Bloss  20a. Method of Disposition  120 Burial 2 Cremation 3 4 Donation 5 Other (Specify)  21. Signature of Funeral Service Licens	Removal from State Fort	ce of Disposition the term of the Linco	on (Name of ory or other place) 1n emetery	Apr.	Date 2	t Airy,MD coc. Location - City or rentwood,	Maryland
Ba	AEUS.		23a. Part Enter the disease, or comp shock, or heart failure. List only o	lications that caused the death.		Univers	ity Blvo	l.,W.,Sil	Home, Inc. ver Spring	Approximate Interval Between Onset and Death
,	/Medical Examiner pricial and pricial sician and pricial sician and pricial sicial sici	Examiner	disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	a. Septic Shock Due to (or as a conseque b. Concestive He Due to (or as a conseque c. Renal Failure Due to (or as a conseque	eart Fa	ilure				
Box 68760,	eath certificate attending phy: for use as the	clan/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	d. Hypertension  23c. If yes, outcome of pregnant  1 Live birth 2 Fetal d  4 Pregnant at time of dea	leath 3 □Ect	opic pregnancy			23d. Date of del Month	ivery Day Year
rds, P.O.	ires that the signed by th d be detache	ompleted by Physiclan/Me	1  Yes 2  No 9  Unknown  Part II. Other significant conditions co	9□ Unknown			n in Part I.		acco use contribute to s 2√No 3 □ Pr	o the cause of death?
Vital Records,	The law ate has b page 2 st	O.	Anemia					24a. Was an autopsy perform	ed? prior to death?	atopsy findings available completion of cause of
of	ding Phys h. After this funeral di	atlon; To Be	27. Manner of Death  1 X Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	8b. Time of Injury	Other 28c. Injury a Work?	4 Nursing H	th (Check only one ome 5  Resider 28d. Describe how	nce 6 Other (Spec	cify)
Division	P 5 5 5	al Certification:	3 Suicide 4 Homicide 6 Could not be determined	building, etc. (Specify)  Sician: To the best of my know	ledge, death oc	curred at the time	date and place	City or Town,	usa(s) and manner as	stated
	To the Hospital within 24 hours at To the Funeral Completely filled in	Medical	(Check only 2 Medical Examinate)  29b. Signature and title of certifier	iner: On the basis of examination and manner stated.	on and/or invest	29c. License	nion, death occur	red at the time, da	te and place, and due	to the cause(s)
	5		30. Name and address of pelson who c				-		pril 11, 2	
	Sta Registr		Ajay Reddy, M.D.  31. Date filed (Month, Day, Year)  APR 12	6320 Democra 32. Figistrar's Signatu	Boul	levard	Bethesda	,Marylan	d 20817-1	664

12:00 noon

10 April 05

Meyers, Dorothy

			State of Many	land / Den	artment of H	Ensure All	ental Hy	Are Legible.	11000
		•	For AMEND#31, see#324/12/03, B.W., Mady Registra AMEND#29 covert M04/12/05, B.W., Mod	to Ce	rtificate of I	Death	Cintai i iy	Reg. No.	14202
			1. Decedent's Name (First, Middle, Last)				2. Date of De.	ath	3. Time of Death
1	Physicia /Medic		Autoinette, V. Mille				Month OH	Day Year	5 1955 M
	Examin		4a. Facility Name (If not institution, give street and number)	· (	4b. City, Town, or	Location of Death		4c. County of Dea	eth .
			77.00	ente	- Anneys -	If Under 24 Hrs.		Arma	41
	Funeral Director		5. Social Security Number 6. Sex 1 M 2 7. Age (In	yrs. last birthday)  88 Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Bird (Month, Da	th 9. Bir y, Year) C	thplace (State or Foreign ountry)
			Usual Residence of Decedent				march	28,1917 N	ew York
	show dat	_		c. City, Town or Lo					10d. Inside City Limits
	he Ma	ecto		Silver S					1 X Yes 2 □ No
	perritt. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show many injury or phar traumatic evant, the Medical Examinat must be notified at ances.	by Funeral Director	8505 Springvale Road #37		10f. Zip Code 20910			10g. Citizen of What C	ountry?
	death ms 23	nera	11. Marital Status 12. Was Decedent Ever	in U.S. 13.		ispanic Origin? (Spe an, Mexican, Puerto F	cify Yes or No	- 14. Race - Am	
9	or ite	Fur	Armed Forces?  1 ☐ Never Married 2 ☐ Married 1 ☐ Yes, 27 No If Yes, Give		If Yes, specify Cuba 1 ☐ Yes 2 ▼ No	an, Mexican, Puerto F Specify:	Rican, etc.)		te, etc.
21215-0036	ural',	d by	3 K widowed 4 □ Divorced Year or Dates:		77.			Specify: Wi	nite
15	"nate	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give	dent's Usual Occup kind of work done o DO NOT use retired	during most of working	ng	16b. Kind of Business	/Industry
12	withi	dwo	Elementary/Secondary (0-12) College (1-4or 5+)	Homen		·/		Own Home	
	e filed al Hygie other vant,	BeC	17. Father's Name (First, Middle, Last)			18. Mother's Name	(First, Middle,	Maiden Sumame)	
lar	should be and Mental marked c	ToE	Frank Wirfel			Victoria	Flis		
Maryland	2 sho l and is ma		19a. Informant's Name/Relationship (Type, Print)		-			er, City or Town, State,	
	1 and 1ealth am 27 thar tr		Judith Whalen, Daughter  20a. Method of Disposition	202 Ob. Place of Dispo			Rockvi	lle, Maryla	
Baltimore,	Pages nent of H int: If its		1 ☐ Burial 2 X Cremation 3 ☐ Removal from State	cemetery, crei	matory or other plac	(e)		20c. Location - City or	
臣	it. Partme		*4 □Donation 5 □ Other (Specify)  21. Signature of Funeral Service Licensee		oln Crema  2. Name and Addres	tory 04/13	3/2005 mple T1	Brentwood,	Maryland
Ba	permit. Departr Importu any inji		Cen June House Ihra	//				ville, Mary	1and 20852
			23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line.						Approximate Interval Between
	Physician ·		Immediate Cause (Final disease or condition	.00.	4 1	211			Onset and Death
	/Medical		resulting in death)  a.  Due to (or as a co	nsequence of):	- 7.	2020		1	00/5
	Examiner	_	Sequentially list conditions, b. Heart	Poulors	٤				maith
	led nsit	cal Examiner	Sequentially list conditions, if any, leading to immediate cause. Line Uniterlying Cause (Disease or injury	nsequence of):					
	al-trai	xar	that initiated events resulting in death) Last C. Due to (or as a co	nsequence of):					
760,	le be executed ysician and e burial-transit	call	d						
99	uires that the death certificate be executed signed by the attending physician and deedeched for use as the burial-transit	Medi	IF FEMALE:						l
Вох	ath ce ttendi	lan/I	23b. Was decedent pregnant in the past 12 months?		⊒Ectopic pregnancy	,		23d. Date of de Month	livery Day Year
	The law requires that the death certifica ate has been signed by the attending phoage 2 should be detached for use as the	Completed by Physician/Med	1 Yes 2 No 4 Pregnant at time 9 Unknown	of death 5[	Other (specify)			Nontri	Day Teal
P.0	that the ed by detac	Ph	Part II. Other significant conditions contributing to death but no	ot resulting in the u	inderlying cause give	en in Part I.	23e. Did to	obacco use contribute t	o the cause of death?
Records,	uires sign Id be	d b	Waldonsfroms Macros	0 0	ienria.		10		robabły 4 Unknown
00	w requires been si	iete	Molan Litai			· · · · · · · · · · · · · · · · · · ·	24a. Was	an 24b. Were a	utopsy findings available
Re	The la	omp						prior to death?	completion of cause of
Vital	ian: rtifica	0	25. Was case referred to medical			26. Place of Death	(Check only o		3 NO
of V	Physician: r this certificanal director,	To B	examiner? 1 ☐ Yes 2 No Hospital: 1 Inpatient	2 ER/Outpatie	-	4   Nursing Hon	ne 5□ Resid	dence 6 □Other (Spe	ecity)
n	ing P		27. Manner of Death 1 Natural 5 □ Pending (Month, Day Ye	ar) 28b. Time o	Wor		.8d. Describe t	now injury occurred	
Division	Attanding ir death. actor: After by the fune	icat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be 389 Place of Injury	At home farm st		Yes 2 □No	19f Logation /	Street and Mumber of D	to the transfer of the transfe
Div	I or A after Dirac	Certification:	4 Homicide determined 28e. Place of Injury - building, etc. (S	pecify)	reet, factory, office	2	City or Tov	Street and Number or R vn, State)	ura i Houte Number,
	To the Hospital or Attanding Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	aic	29a. Certifier Certifying Physician: To the best of m	y knowledge, deat	h occurred at the tin	ne, date and place, a	nd due to the	cause(s) and manner a	s stated.
	he Ho in 24 I ha Fu pletely	Medicai	(Check only one) 2 Medical Examiner: On the basis of examiner on the basis of examiner stated	amination and/or in	vestigation, in my o	pinion, death occurre	d at the time,	date and place, and du	e to the cause(s)
		Σ	29b. Signature and title of certifier	18	29c. Licens	61783		29d. Date signed (Mon.	
•	7		, Cyca	مرق <sub>ع</sub>	Day	· Doo6/7	83	4-8-0	5
			30. Name and address of person who completed cause of death	03		0		0 21401	
	Sta	te.	31. Date filed Month, Day, Year)  32. Registrar's	Signature	ewy 1	runcy	1 100	1 2 140	
	Registi		H-8-5- MAPR	1 2 2005	Book	St Appen	E. C.		

			1 - For State Registrar	State of	Marylar		artmer			and M	lental I		ene (	)5	14203
		П	1. Decedent's Name (First, Middle, Last)	*							2. Date o	f Death		V	3. Time of Death
	Physici /Medio		Max J. Mil	lman							Apri.		Day 2005	Year	8:20 PM
	Examir		4a. Facility Name (If not institution, give s MARINER HEALTHCARE		oer)				Location of				4c. Count		Y
	Funeral Director		5. Social Security Number 6. Sex 374-09-5796	M 2□F 7.	Age (In yrs.	last birthday) Yrs.	If Under Months	Days	If Under	24 Hrs. Min.	8. Date o (Month 11/	f Birth , $_{Day}$	Ye <i>ar)</i> 913	9. Birthi Cour POL	place (State or Foreign ntry) AND
	/land		10a. State 10b. County		10c. Ci	ity, Town or Lo	cation								10d. Inside City Limits
	a-f st	ctor	MD MONTGO	MERY		SILVE	RSPR	ING							1∭Yes 2 □ No
	or 28	Director	10e. Street and Number				10f. Zip					10	g. Citizen of	What Cou	ntry?
	eth w	rail	1131 UNIVERSITY BL				2	0902				U	.S.A.		
980	permit. Pages 1 and 2 should be filed within 72 hours efter deeth with the Maryland Department of Health and Mental Hyglene. Important: if item 27 is marked other than "natural", or items 23e or 28e-f show enjury or other traumatic event, the Medical Evantius transit by ricitified at ODGs.	by Funeral	11. Marital Status  1 □ Never Married 2 Married  3 □ Widowed 4 □ Divorced	I2. Was Decedo Armed Forc 1 ☐ Yes 2 If Yes, Give Year or Dato	es? M∑No		Was Dece f Yes, spe 1 ☐ Yes	cify Cuba	spanic Ori n, Mexican Specity:	gin? (Spe i, Puerto	ecify Yes o Rican, etc.	r No- .)	Bia	ce - Americk, White, fy: WHI!	etc.
5	72 ho	Completed	15. Decedent's Educ (Specify only highest grade	cation		16a. Dece	dent's Usu	al Occupa	ation Juring most	of work	ina	10	6b. Kind of E	lusiness/In	dustry
2	within ne.	mple	Elementary/Secondary (0-12)	College (1-4	or 5+)	life.	DO NOT u	se retired	)	OF WORK	ng		FURNIT	שמווי	
i D	illed v Hygie ther t		12 years  17. Father's Name (First, Middle, Last)			SALI	ESMAN	-	19 Mothe	r'o Name	/First 14i		aiden Sumai		*
Maryland 21215-0036	nould be I Mental I harked of hatic eve	To Be	LOUIS MILLMAN						IDA		DURC	HIN		,	
ă	d 2 sh th and th and 17 is m		19a. Informant's Name/Relationship (Tyr.  RUTH R. MILLMAN/W			19b. Mailir	ng Address INTVF	<i>(Street a</i> RSTT	i <i>nd Numb</i> e Y BT.V	r or Rura D. W	A Route No	umber, (	City or Town	State. Zic	R SPRING,
ē,	s 1 an f Heal item 2 other		20a. Method of Disposition		20b.	Place of Dispo	sition (Na	me of			Date	-	Oc. Location	1D 20	
E	Pages nett of int: if	,	1 ☑ Burial 2 ☐ Cremation 3 ☐ R.  '4 ☐ Donation 5 ☐ Other (Specify)	emoval from St	ale	cemetery, crer T • LEBA	-	other place		/10/	2005		ADELI	PHI, I	MD
Baltimore,	permit. Departmine imports eny inju		21. Signature of Funeral Service License	Dist	dem	es El	Name ar DWARD 091 R	Addres SAG OCKV	s of Facilit EL FU ILLE	NERA PIKE	L DIF	RECT	ION, I	INC 1D 20	852
,	Physician	3 1	23a. Part1. Enter the disease, or complications, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	e cause on eac	used the debt line.  JMONIA		er the mod	de of dying	g, such as	cardiac o	or respirato	ry arres	st,		Approximate Interval Between Onset and Death 2 DAYS
	/Medical Examiner		Tooling in death,	Due to (or	as a consec	quence of):									
		er	Sequentially list conditions, if any, leading to immediate	Due to (or	as a consec	quence of):								-	
	outed od ransit	Examiner	if any, leading to immediate cause. Enter Undertying Usesse Try that initiated events												
Ö,	icate be executed physicien and s the burial-transit	Exa	resulting in death) Last		as a consec	quence of):									
8760,	ate b physic the bi	dical	d												
Box 6	ath certif attending for use as	Physician/Med	in the past 12 months?		ome of pregn h 2 ☐ Feta	aldeath 3□	Ectopic pr							ate of delive	ery Day Year
o.	that the de led by the s deteched t	yslo	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9☐ Unknow		10a(ii 5 L	Other (sp	юспу)							
Records, P.	juires that n signed b ild be dete	þ	Part II. Other significant conditions con CHRONIC RENAL		th but not res	sulting in the u	nderlying o	ause give	en in Part I.						ne cause of death?
S	aw requir s been si 2 should t	olete									24a. \	Vas an	24b.	Were auto	psy findings available
	The lav	Completed									1 D Y	utopsy erforme	ed?	prior to co death?	mpletion of cause of 2 No
Vital	ysician: The is certificate director, pag	Be C	25. Was case referred to medical examiner?						26. Place	of Death	(Check of				2010
<u></u>	shysic this co	ို	1 ☐ Yes 2X No			ER/Outpatier	-	OA Othe	0F. 4 <b>∑</b> Nu	rsing Ho	me 5□£	Residen	ce 6 Oth	ner (Specif	y)
Division of	ding Phi h. After thi funeral	lon	27. Manner of Death  1X Natural 5 ☐ Pending	28a. Date of (Month,	Injury Day Year)	28b. Time of Injury		8c. Injury Work	:?		28d. Descr	ibe how	injury occur	rred	
S	deal deal ctor: y the	ficat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	28e Place of	f Injury - At h	ome, farm, str	M eet factor		/es 2□1		28f Locatio	on (Stre	et and Numi	her or Pum	Il Route Number,
2	in Dirth	Certification	4 Homicide determined	building	, etc. (Speci	fy)	oot, taotor	, 011100			City or	Town,	State)	Jor or riare	r noute number,
	To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b	Medical C	29a. Certifier 1 Certifying Phys	sician: To the bear: On the bas and manne	is of examina	owledge, death ation and/or in	n occurred vestigation	at the tim	e, date and pinion, deat	d place, a	and due to ed at the ti	the cau	ise(s) and m e and place,	anner as s and due to	tated. o the cause(s)
	To th within To the	Me	29b. Signature and title of certifier	//	11		290	c. License	number			290	d. Date signe	ed (Month,	Day, Year)
			> Bell	Caper	ch			D09	834				APR	IL 8,	2005
	10		30. Name and address of person who co BARRY N. ROSENBAUM					/E.,	KENSI	ENGT(	ON, M	_ D 20	0891		
	Sta	te	31. Date filed (Mora PR Year) 2 2	105 32. Peg	jistrar's Sign		nave						23000		
	Registr	ar		1	PISED .	10 12	-								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygierie 15 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Julia 8 Farley April 2005 9:55 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Montgomery General Hospital Olney Montgomery | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Aug. 9, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year Months Days Birthplace (State or Foreign Country) Months 1 ☐ M 2 🛛 F 579-36-2019 74 Yrs Washington, DC Usual Residence of Decedent 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits Maryland Montgomery Silver Spring 1 ☐ Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2904 N. Leisure World Blvd. #510 20906 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ② No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2X No Specify White Specify: 3 X Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Benefit Planner **GEICO** 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Thomas J. Farley Marie M. Reis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Farley Muse / Son 37 Fawn Trail Fairfield, Pennsylvania 17320 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State April 14, St. Peter's Cemetery 1 4 □Donation 5 □ Other (Specify) 2005 Oak Grove, Virginia 22. Name and Address of Facility DeVol Funeral Home 21. Signature of Funeral Service Licensee 10 E. Deer Park Dr. Gaithersburg, MD 20877 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Sepsis disease or condition resulting in death) Due to (or as a consequence of): End Stage Alcoholic Liver Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of) 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 2 Fetal death 3 □Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) 9☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? E 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown

**Physician** /Medical Examiner

The law raquires that the death certificate be executed

Hospitel or Attending Physiclan:

To the

10

death.

Foxed to ME OK DEV HE Division of Vital Records, P.O. Box 68760,

**Physician** 

/Medical

Examiner

Direct

Funeral

þ

Completed

Be

ဂ္

**Funeral** 

Director

the Maryland

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "naturel", or items 23a or 28a-f show any injury or other treumatic event, the Medical Examinating the notified at once.

Baltimore, Maryland 21215-0036

Examiner

burial-transit physician Physician/Medical the igned by the attending I be detached for use as peubis þ Completed been this the funeral After 1 within 24 hours after deat To the Funerel Director:

IF FEMALE 9 Unknown 25. Was case referred to medical

3 Suicide

4 | Homicide

Certification: ical 29a. Certifier

23b. Was decedent pregnant in the past 12 months?

Ethanol	Abuse				
					 _
-		 	 	 	 _

1 X Inpatient 2 ER/Outpatient 3 DOA

24a, Was an autopsy performed? 1 Yes 2 X No 26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 \( \text{No} \)

examiner' 1 ☐ Yes 2X No 27. Manner of Death 1 X Natural 5 Pending 2 Accident

28a. Date of Injury (Month, Day Year) investigation 6 Could not be determined

28b. Time of 28c. Injury at Work? 1 Tes 2 No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number City or Town, State)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier

D62588

29d. Date signed (Month, Day, Year) 04/08/05

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

boug

7513 NEW HAMPSHIRE AVE TOKOMA PARK NO 20912 J. MBAUUIA MA

170

31. Date filed (Month, Day, Year) gistrar's Signature

State Registrar APR 12



Paul Morgan 05-2540 AKG

J-41	o .			partment of Health and N ertificate of Death		ene 005 14205
			Decedent's Name (First, Middle, Last)		2. Date of Death	3. Time of Death
	Physici /Medio		Paul Gilbert Morgan,Jr.		April 11	Day Year 5:04 P
}	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death
			Southern Maryland Hospital	Clinton	,	Prince George's
	Funeral		5. Social Security Number 217-58-7445 6. Sex 1. Age (In yrs. last birthda 2 F	(y) If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth July 29	9. Birthplace (State or Foreign Country) 1958 Maryland
	Director		Usual Residence of Decedent		July 29	,1930 Maryrand
	yland Now		10a. State 10b. County 10c. City, Town or			10d. Inside City Limits
	Mar st	ģ	MD Charles Wald	ort		1 ☐ Yes 21X No
	or 28	)ire	10e. Street and Number	10f. Zip Code	10	g. Citizen of What Country?
	23a	ral	4735 Hummingbird Drive	20603		USA
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Itam 27 is marked other than "natural", or Items 23e or 28e-f show any Injury or other traumatic evant, I're Medical Examiner niust be nuitified at once.	Completed by Funeral Director	11. Marital Status  1 □ Never Married 2 ☒ Married  1 □ Never Married 2 ☒ Married  1 □ Never Married 2 ☒ Married  1 □ Yes ② ☐ No If Yes, Give Year or Dates:	<ol> <li>Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerton 1 ☐ Yes 2 XNo Specify:</li> </ol>	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
Ō	72 ho	ted		cedent's Usual Occupation ve kind of work done during most of work	10	6b. Kind of Business/Industry
2	ithin 7	npie	Elementary/Secondary (0-12) College (1-4or 5+)	o. DO NOT use retired)	arig	County
2	ygien ygien yer th			olice Officer		Law Enforcement
ğ	be fill Hall Hall Hall Hall off	Be	17. Father's Name (First, Middle, Last)	18. Mother's Nam	e (First, Middle, Ma ia Mart	
2	should ind Men s marke umatic	2	Paul G. Morgan, Sr.  19a. Informant's Name/Relationship (Type, Print)  19b. Ma			
Z	d 2 s th an th an traur		Dianna Morgan/Wife 47	illing Address <i>(Street and Number or Rui</i> 35 Hummingbird	Drive, Wa	aldorf, MD 20603
Ġ,	s 1 and 2 of Health a Itam 27 Is		20a. Method of Disposition 20b. Place of Dis	position (Name of	_	0c. Location - City or Town, State
ē	Pages nent of int: If It iry or o			rematory or other place) natius Cem. 4/1.		ort Tobacco,MD
Baltimore, Maryland 21215-0036	permit. F Departme Importar any Injur		21. Signature of Funeral Service Licensee M00945	22AREHARTSECHOLS	FUNERAI	L HOME, P.A.
			23a. Part1. Enter the disease, or complications that caused the death. Do not	P.O. BOX 567, L.		st, Approximate
	Physician		shock, or heart failure. List only one cause on each line.  Immediate Cause (Final	11120		Interval Between Onset and Death
	/Medical		disease or condition resulting in death)  a	uries		
	Examiner					
	B =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause juisease or injury			
	acute and trans	Examiner	that initiated events c.			
8760,	cate be executed obysician and the burial-transit	Ē	Due to (or as a consequence of):			
87	cate I physi the t	dicai	d			
9 x	The law requires that the death certific ate has been signed by the attending p page 2 should be detached for use as	by Physician/Me	IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of delivery
Вох	death a atter d for u	ciar		B □Ectopic pregnancy □ □ Other (specify)		Month Day Year
o.	that the di ed by the detached	hys	9 Unknown			
S, D	res thai signed to be det	y P	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did toba	acco use contribute to the cause of death?
ğ	v require been sig should t	ed			1 ☐ Yes	2 X No 3 Probably 4 □Unknown
Vital Record	e law re has be ge 2 sho	Completed			24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
Œ		Con			performe	
/ita	ysician; Th is certificate director, pag	Be	25. Was case referred to medical examiner?		h (Check only one)	
	hys this al dii	2	Yes 2 No Hospital: 1 Inpatient 2 ER/Outpat			ce 6 □Other (Specify)
u C	ding l	ion	27. Manner of Death  1 Natural 5 Pending (Month, Day Year)  28b. Time (Month, Day Year)	Work?	28d. Describe how	a motorcycle struck
Si	Attanding Physician: r death. ector: After this certific by the funeral director,	licat	2 CAccident investigation 3 Suicide 6 Could not be determined to be determ			et and Nymber or Rural Route Number,
Division of	after after Dire	Certification:	4 Homicide determined building, etc. (Specify)	3	City or Town, Waldert	State) West Small wood drive
	To tha Hospital or Attanding F within 24 hours after death. To tha Funaral Director: After completely filled in by the funer.	edicai C	29a. Certifier  (Check only 2 Medical Examiner: On the basis of examination and/or	ath occurred at the time, date and place,	and due to the cau	ISSE(S) and manner as stated.
	tha hin 24 tha F	Medi	and manner stated.			
	To Your	~	29b. Signature and title of certifier  M. M. M. D	29c. License number  OCME		d. Date signed (Month, Day, Year)
0					Ap	pril 12, 2005
1	88		30. Name and address of person who completed cause of death (Item 23a) (Typ	e, Print) 111 Penn Stree	t Balti	more, Maryland 21201
	Sta	te	31. Date filod (Month, Day, Year) 32. Restrar's Signature			
	Registr	4	31. Date filod (Month, Day, Year)  APR 1 3 2005	Marie		

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav Month Year **Physician April** 2005 /Medical 6:40 A 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 3043 Turkey Point Road Cecil 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1[XM 2□ F Director 219 34 2187 Yrs. 69 Jan.7,1936 Virginia Usuel Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ir than "natural", or Items 23a or 28a-f show tre Medical Examinar must be notified at Director 1 ☐ Yes 2X No Maryland Cecil North East 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 3043 Turkey Point Road Funeral 21901 United States 12. Was Decedent Ever in U.S. Agned Forces?

14 Yes 2 DNo 1956—
If Yes, Give Year or Dates: 1958 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 🎾 No Specify: white Specify: white ģ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 11 <u>Meat Cutter</u> Grocery store t of Health and Mental Hyg If Item 27 is marked othe or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) pe Fred Musick Lula Harmon Pages 1 and 2 should 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Allie Musick/Wife 3043 Turkey Point Road, North East, Maryland 21901 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State North East Methodist April 16, 3 Removal from State perrit. Page Depirtment of Important: If any injury or Cemetery 2005 North East, Maryland 22. Name and Address of Facility Crouch Funeral Home 127 South Main Street, North East, Maryland 21901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician minso /Medical Due to (or as a consequence of Examiner tthevosc Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transit IPEV (Notes Die to (or as a consequence of) Completed by Physician/Medical use as 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Dav Year 4 Pregnant at time of death 5 Other (specify) Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2. No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? tension 24a. Was an autopsy performed 1 ☐ Yes 1 ☐ Yes 2 ☐ No 2 No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: After 5 Pending investigation 1 Natural within 24 hours after death.

To the Funeral Director: A
completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide Leading Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number arey ted cause of deeth (Item 23a) (Type, Print) 32. Registrar's Signature 31. Date filed (Month, Day, Year) State APR 13 2005 Registrar

DHMH 17 Rev 1/2001

Box 68760

O

of Vital

Division

December 1   December 1   December 1   December 1   December 1   December 1   December 2   December 2   December 3   Dec				For State	State of Maryl		artment of H			2000	14207
Examiner  1. Sealing hymner for exhances you are early and an appear of the property of the pr					st)				2. Date of Dea	ath	
See Training was referred to send on the control of				Zelma	Cece	elia	Mi	ller	/R .	Day Year	
Fundamental Direction   1				4a. Facility Name (If not institution, give	e street and number)	. ^	4b. City, Town, or	r Location of De		4c. County of De	
21.35 - 1.6 - 2.93 0					urt Haspi	tap	Cum	berlas	X	Alleg	any
Use a Best Work of Control C						•			in. 8. Date of Birth	(Year)	Country)
The Depotency County of the Price of Villiams (Chapter) and Allegary (County County Co				218-10-2730	_ A 03	113.			02/22/19.	ZZ Pei	nnsylvania
State   Prival Cition   Priv		yland			100	. City, Town or L	ocation				10d. Inside City Limits
State   Prival Cition   Priv		Mar e-f st	ctor	MD Alle	egany		Cumberlar	nd			1 ☐ Yes 2 🖔 No
State   Prival Cition   Priv		or 28	Oire	10e. Street and Number			10f. Zip Code			10g. Citizen of What 0	Country?
State   Prival Cition   Priv		ath w			T						
State   Prival Cition   Priv		er de	nne		Armed Forces?	in U.S. 13.	Was Decedent of Hi If Yes, specify Cuba	ispanic Origin? In, Mexican, Pu	(Specify Yes or No- erto Rican, etc.)	14. Race - An Black, Wh	
State   Prival Cition   Priv	36	rs aft	by F		If Yes, Give		1 ☐ Yes 2 ☐ No	Specify:		Specify:	White
State   Prival Cition   Priv	Ş	2 hou	ted	15. Decedent's E	ducation	16a. Dece	dent's Usual Occupa	ation		16b. Kind of Busines	
State   Prival Cition   Priv	212	hin 7.	ple			(Give	n kind of work done of DO NOT use retired	during most of v 1)	working		
State   Prival Cition   Priv	7	ed wit	Con	8			Homemaker			Homemake	r
Fred T. Miller / Son  Fred T. Miller / Son  Fred T. Miller / Son  Fred T. Miller / Son  Fred T. Miller / Son  Fred T. Miller / Son  Fred T. Miller / Son  Fred T. Miller / Son  Fred T. Miller / Son  Fred T. Miller / Son  J. Danels of Depaston  J. Danels	<u>n</u>	e d la b	Be			D1	J				
Fred T. Miller / Son  Fred T. Miller / Son  Fred T. Miller / Son  Fred T. Miller / Son  Fred T. Miller / Son  Fred T. Miller / Son  Fred T. Miller / Son  Fred T. Miller / Son  Fred T. Miller / Son  Fred T. Miller / Son  J. Danels of Depaston  J. Danels	$\frac{8}{5}$	d Mer narke natic	ြ								7. 0. 1.1
Agrowmate character complexations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.    Approximate character class (Final Services of the character complexations that caused the death.) Do not enter the mode of dying, such as cardiac or respiratory arrest. Interval Barween character class (Final Services of the character complexations that caused the death.)	<u>s</u>	d2s than than traur		. ' '			-				, Zip Code)
Agrowmate character complexations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.    Approximate character class (Final Services of the character complexations that caused the death.) Do not enter the mode of dying, such as cardiac or respiratory arrest. Interval Barween character class (Final Services of the character complexations that caused the death.)	ā,	Heal Heal tem 2				h. Place of Disno	nsition (Name of	1			or Town, State
Agrowmate character complexations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.    Approximate character class (Final Services of the character complexations that caused the death.) Do not enter the mode of dying, such as cardiac or respiratory arrest. Interval Barween character class (Final Services of the character complexations that caused the death.)	ē	Pages ent of ht: If I							7/2005	Cumberla	nd. MD
23s Part Letter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.  Approximate Approximate Content of the mode of dying, such as cardiac or respiratory arrest.  Approximate Approximate Content of the mode of dying, such as cardiac or respiratory arrest.  Approximate Approximate Content of the mode of dying, such as cardiac or respiratory arrest.  Approximate Approximate Content of the mode of dying, such as cardiac or respiratory arrest.  Approximate Approximate Content of the mode of dying, such as cardiac or respiratory arrest.  Approximate Approximate Content of the mode of dying, such as cardiac or respiratory arrest.  Approximate Approximate Content of the mode of dying, such as cardiac or respiratory arrest.  Approximate Approximate Content of the mode of dying, such as cardiac or respiratory arrest.  Approximate Approximate Content of the mode of dying, such as cardiac or respiratory arrest.  Approximate Approximate Content of the mode of dying, such as cardiac or respiratory arrest.  Approximate Approximate Content of the mode of dying, such as cardiac or respiratory arrest.  Approximate Approximate Content of the mode of dying, such as cardiac or respiratory arrest.  Approximate Approximate Content of the mode of dying, such as cardiac or respiratory arrest.  Approximate Approximate Content of the mode of dying, such as cardiac or respiratory arrest.  Approximate Approximate Content of the mode of dying, such as cardiac Content of the mode of dying, such as cardiac Content or Content of the mode of the mod	=	ocrtan Cinju						1			
Physician Medical Examinor  Physician Medical Examinor  The Court of the state of t	m	<u>8</u> <u>8</u> <u>8</u> <u>8</u>		* Labert (	Man		404 Decatur	r Street,	Cumberland	, Maryland	21502
Physician Middellal Examiner    Page   Physician Midellal   Physician Mi	ı			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the cone cause on each line.	death. Do not en	ter the mode of dyin	g, such as card	liac or respiratory arr	rest,	Interval Between
Sequentially list conditions, cause. Enter Underlying Cause (Desase or injury) Tresulting in death) Last    Sequentially list conditions, cause. Enter Underlying Cause (Desase or injury) Tresulting in death) Last   Sequentially list conditions, cause. Enter Underlying Cause (Desase or injury) Tresulting in death) Last   Sequentially list conditions, cause. Enter Underlying Cause (Desase or injury) Tresulting in death) Last   Sequentially list conditions, cause. Enter Underlying Cause (Desase or injury) Tresulting in death) Last   Sequentially list conditions, cause. Enter Underlying Cause (Desase or injury) Tresulting in death) Last   Sequentially list conditions, cause (Desase or injury) Tresulting in death) Last   Sequentially list conditions, cause (Desase or injury) Tresulting in death) Last   Sequentially list conditions, cause (Desase or injury) Tresulting in death) Last   Sequentially list conditions, cause (Desase or injury) Tresulting in death) Last   Sequentially list conditions, cause (Desase or injury) Tresulting in death) Last   Sequentially list conditions, cause (Desase or injury) Tresulting in death) Last   Sequentially list conditions, cause (Desase or injury) Tresulting in death) Last   Sequentially list conditions, cause (Desase or injury) Tresulting in death) Last   Sequentially list conditions, cause (Desase or injury) Tresulting in death) Last   Sequentially list conditions, cause (Desase or injury) Tresulting in death) Last   Sequentially list conditions, cause (Desase or injury) Tresulting in death list conditions, cause (Desase or injury) Tresulting in death list conditions, cause (Desase or injury) Tresulting in death list conditions and time of death list conditions and list conditions and list conditions and list conditions and list conditions and list conditions and list conditions and list conditions and list conditions and list conditions and list conditions and list conditions and list conditions and list conditions and list conditions and list conditions and list conditions and	А			disease or condition	(imgest)	ive He	ast fo	rillive			Onset and Death
State  Sequentially list conditions, and continued and sequence of the sequenc	ſ.			resulting in death)	Due to (on as a con	sequence of):		~			
Due to (or as a consequence of):  d. CLCCL GLcd. CLSCCC. GLcd. CLSCCC. GLcd. CLSCCC. GLcd. CLSCCC. GLcd. CLSCCC. GLcd. CLSCCC. GLcd. CLSCCC. GLcd. CLSCCC. GLcd. CLSCCC. GLcd. CLSCCC. GLcd. CLSCCC. GLcd. CLSCCC. GLcd. CLSCCC. GLcd. CLSCCC. GLcd. CLSCCC. GLcd. CLSCCC. GLcd. CLSCCC. GLcd. CLSCCC. Glcd. CLSCCC. Glcd. CLSCCC. Glcd. CLSCCC. Glcd. CLSCCC. Glcd. CLSCCC. Glcd. Clscc. Glcd. Clsc. Glcd. Clscc. Glcd. Clsc. Gl	П	LAGIIIIII	-	Sequentially list conditions,	P. Groom	Mal	Depols	5			Jacq
Due to (or as a consequence of):  d. CLCCL GLcd. CLSCCC. GLcd. CLSCCC. GLcd. CLSCCC. GLcd. CLSCCC. GLcd. CLSCCC. GLcd. CLSCCC. GLcd. CLSCCC. GLcd. CLSCCC. GLcd. CLSCCC. GLcd. CLSCCC. GLcd. CLSCCC. GLcd. CLSCCC. GLcd. CLSCCC. GLcd. CLSCCC. GLcd. CLSCCC. GLcd. CLSCCC. GLcd. CLSCCC. GLcd. CLSCCC. Glcd. CLSCCC. Glcd. CLSCCC. Glcd. CLSCCC. Glcd. CLSCCC. Glcd. CLSCCC. Glcd. Clscc. Glcd. Clsc. Glcd. Clscc. Glcd. Clsc. Gl		nsit	nlne	cause. Enter Underlying Cause (Disease or injury	305 10 10 10 20 20 00	a Ala	NICE TOWN	L. Burn	or Port	we from	7 do
FEMALE:   23b. Was decedant pregnant   1   23c. If yes, outcome of pregnancy   1   23c. If yes outcome of pregnancy   1   23c. If yes outcome of pregnancy   1   23c. If yes outcome of pregnancy   1   23c. If yes outcome of yes of pregnancy   1   23c. If yes outcome of yes	<u>,</u>	execunand ial-tra	Exal	triat initiated events	Due to (or as a con	sequence of):	WELL EVELY	LIBORES	121	ALEX WY 1	radio
FFEMALE:   236. If yes, outcome of pregnancy   1   Live birth   2   Fetal death   3   Ectopic pregnancy   236. Date of delivery   Month   Day   Year   1   Yes   2   No   3   Probably   4   Pregnancy   1   Live birth   2   Fetal death   5   Other (specify)   236. Date of delivery   Month   Day   Year   1   Yes   2   No   3   Probably   4   Pregnancy   1   Live birth   2   Fetal death   5   Other (specify)   236. Date of delivery   Month   Day   Year   1   Yes   2   No   3   Probably   4   Pregnancy   4	76	te be yskie ne bur		(	. Incarco	rated	Incis	ional	derni	a	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.    Part II. Other significant conditions contribute to the cause of death?	9	ntifica ing ph		IE EEMALE:							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.    Part II. Other significant conditions contribute to the cause of death?	ã	ath ce ttendi	lan/I	23b. Was decedent pregnant	1 ☐ Live birth 2 ☐ F	etal death 3					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.    Part II. Other significant conditions contribute to the cause of death?		the a	ysic	1 ☐ Yes 2 X No		of death 5[	Other (specify)			Worth	ouy roar
The state of the s	٥.	that the			contributing to death but not	resulting in the u	anderlying cause give	en in Part I.	23e. Did to	bacco use contribute	to the cause of death?
25. Was case referred to med saminer?    26. Place of Death (Check only one)	g <sub>s</sub>	uires sign ld be	β	anterstital	Puna Fr	brosi	9		1 🗆 Y	es 2 □ No 3 € F	robably 4 Unknown
25. Was case referred to med saminer?    26. Place of Death (Check only one)	00	s beer shou	lete	Chronic Obs.	Muchid P	ulmar	Va Die	500 00	24a. Was a	an 24b. Were a	autopsy findings available
25. Was case referred to med saminer?    26. Place of Death (Check only one)		The la te has age 2	ошо	Corcons in	Oxless T	Jisones	0900	Rane	perfor	sy prior to med? death?	completion of cause of
1   Yes   2   No   1   Minpatient   2   ER/Outpatient   3   DOA   4   Nursing Home   5   Residence   6   Other (Specify)    27. Manner of Death   1   Natural   2   Accident   1   Yes   2   No   1   Yes   2   No    28a. Date of Injury   28b. Time of Injury   28b. T	ta		0	25. Was case referred to med	MACIA T	الالالع		26. Place of D			5 2 140
29a. Certifier  29a. Certifier  (Check only one)  29a. Signature and title of completed cause of death (Item 23a) (Type, Print)  29b. Signature and a Markess person who completed cause of death (Item 23a) (Type, Print)  29c. License number  29d. Date signed (Month, Day, Year)  31. Date filed (Month, Day, Year)  32 Pegistrar's Signature  29a. Certifier  29b. Signature and title of cause(s) and manner as stated.  29b. Signature and title of cause(s)  29c. License number  29d. Date signed (Month, Day, Year)		nysic nis ce I direc	0		Hospital: 1 Anpatient	2 ER/Outpatie	nt 3 DOA Othe	er: 4 🗆 Nursing	Home 5 Reside	ence 6 □Other (Sp	ecify)
29a. Certifier  29a. Certifier  (Check only one)  29a. Signature and title of completed cause of death (Item 23a) (Type, Print)  29b. Signature and a Markess person who completed cause of death (Item 23a) (Type, Print)  29c. License number  29d. Date signed (Month, Day, Year)  31. Date filed (Month, Day, Year)  32 Pegistrar's Signature  29a. Certifier  29b. Signature and title of cause(s) and manner as stated.  29b. Signature and title of cause(s)  29c. License number  29d. Date signed (Month, Day, Year)	0	Ing PI			28a. Date of Injury (Month, Day Yea		Work	k?	28d. Describe ho	ow infury occurred	
29a. Certifier  29a. Certifier  (Check only one)  29a. Signature and title of completed cause of death (Item 23a) (Type, Print)  29b. Signature and a Markess person who completed cause of death (Item 23a) (Type, Print)  29c. License number  29d. Date signed (Month, Day, Year)  31. Date filed (Month, Day, Year)  32 Pegistrar's Signature  29a. Certifier  29b. Signature and title of cause(s) and manner as stated.  29b. Signature and title of cause(s)  29c. License number  29d. Date signed (Month, Day, Year)	<u>S</u>	tendi Jeath. tor: A the fu	catl	2 Accident investigation	10			Yes 2 □No	206 1		
29a. Certifier (Check only one)  29a. Certifier (Check only one)  29a. Certifier (Check only one)  29b. Signature and title of certifier  29c. License number  29c. License number  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  31. Date filed (Month, Day, Year)  32 Pegistrar's Signature  31. Date filed (Month, Day, Year)	$\leq$	or Al after of Direct in by	ertif	dotorminos	289. Place of Injury - A		reet, factory, office				Hurai Houte Number,
30. Name and a strass person who completed cause of death (Item 23a) (Type, Print)  While It. Julic F. Bidec 600 Memorial Rue Stute 402 Clember and MD2562  State 31. Date filed (Month, Day, Year)  32 Registrar's Signature	_	spitations ours inled		29a. Certifier 1X Certifying Pi	nysician: To the best of my	knowledge, deat	th occurred at the time	ne, date and pla	ace, and due to the c	ause(s) and manner a	as stated.
30. Name and a strass person who completed cause of death (Item 23a) (Type, Print)  While It. Julic F. Bidec 600 Memorial Rue Stute 402 Clember and MD2562  State 31. Date filed (Month, Day, Year)  32 Registrar's Signature		ne Ho	odlo	(Check only 2 Medical Exa	miner: On the basis of exam	nination and/or in	vestigation, in my op	pinion, death oc	ccurred at the time, d	late and place, and du	ue to the cause(s)
30. Name and a strass person who completed cause of death (Item 23a) (Type, Print)  While It. Julic F. Bidec 600 Memorial Rue Stute 402 Clember and MD2562  State 31. Date filed (Month, Day, Year)  32 Registrar's Signature		To th withir To th comp	ž	29b. Signature and title of certifier			29c. License	e number	2	29d. Date signed (Mor	nth, Day, Year)
State 31. Date filed (Month, Day, Year) 32 registrars Signature		/		X	MD		Doo	6140L		04-04-	05
State 31. Date filed (Month, Day, Year) 32 registrars Signature			d	30. Name and a stross person who	completed cause of death (	(Item 23a) (Type,	Print)	5	/	7 , ,	
Registrar APR 0 6 2005				31 Date filed (Month Pay Vaar)	clec 600	/ Km	ral Ru	c Du	tc 402 (	lember to	nd MD21502
						Ji Go	all .				

,,,	Ü		For State Registrar	State of Mai	-	partment of e <i>rtificate o</i>		ınd Mental Hyç	giene neg. vro. 05	14208
	Physici	e. an	1. Decedent's Name (First, Middle, Last)					2. Date of Dea	. Day Year	3. Time of Death
	/Medic	al.	Alvin P.	Mayhew		4b. City, Town	and another a	April		22:39 P <sup>M</sup>
	Examin	er	4a. Facility Name (If not institution, give s			Cheve:		r Death	4c. County of Death Prince Ge	roge's
	Funeral		Prince George's Ho 5. Social Security Number 6. Sex	7. Age	iter (In yrs. last birthda	y) If Under 1 Yea	ar If Under 2	24 Hrs. 8. Date of Birth		place (State or Foreign
	Director		377-13-9300	M 2□F	17 Yrs.	Months Day	s Hours	8. Date of Birt Min. (Month, Day Aug. 17	,1987 Wash	n.D.C.
	and		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or	Location				I Od. Inside City Limits
	Mary! f sho	ţō	D.C.		Washi	ngton				₩ Yes 2 No
	r 28a	Director	10e. Street and Number			10f. Zip Code	)		10g. Citizen of What Cour	ntry?
	23a c		5093 Just St	. N.E.		2.0	019		U.S.A.	
36	72 hours after death with the Maryland "natural", or itams 23a or 28a-f show offed Examither out be notified at	by Funeral	11. Marital Status  ★□ Never Married 2 □ Married  3 □ Widowed 4 □ Divorced	12. Was Decedent Ev Armed Forces? 1 ☐ Yes 2 ★ No If Yes, Give Year or Dates:	ver in U.S. 13	B. Was Decedent of If Yes, specify Control of Italian No. 1		gin? (Specify Yes or No- , Puerto Rican, etc.)	Specific	
9	72 hou		15. Decedent's Educ (Specify only highest grade	cation	16a. Dec	cedent's Usual Occ	upation	of working	16b. Kind of Business/In	
21	d within 72 giene. r than "na	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	)	ve kind of work dor DO NOT use reti	red)	or working		
12	70 70 10		17. Father's Name (First, Middle, Last)		3	tudent	18 Mother	r's Name (First, Middle,	School Maiden Sumame)	
and	a d d d	To Be		ddie			10. 141011101	Janice	M. Mayhew	7
Maryland 21215-0036	ges 1 and 2 should L t of Health and Ment if itam 27 is markac or othar traumatic a	_	19a. Informant's Name/Relationship (Ty, Yolanda Rogers	oe, Print) Aunt					r, City or Town, State, Zip tchelville	
Baltimore,	Pages 1 a ment of Herant: if itam lury or othe		20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐ R  `4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	cemetery, c	position (Name of rematory or other p y Mem. C	lace)	pr.12,05	20c. Location - City or To Landover,	MD
Bail	permit. Page Department of important: if any injury or once.		21. Signature of Funeral Service License	funt			nedy	St.N.W.WA	neral Home sh.D.C.200	
	Fnysician /Medical Examiner	er	23a. Pant1. Enter the disease, or complishock, or heart failure. List only or immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to himmediate cause. Enter Underlying Cause (Disease or injury)	Due to (or as a	consequence of):	mod of	Am	011	the	Approximate Interval Between Onset and Death
8760,	le be executed ysician and e burial-transit	Ical Examine	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		consequence of):			·		
.O. Box 68	death certifical e attending phy ed for use as th	Physiclan/Medlo	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at ti 9 □ Unknown	Fetal death	B ☐ Ectopic pregnal Diagram of their (specify)	ncy	-	23d. Date of delive Month	ery Day Year
s, P	w requires that the been signed by th should be detache	by	Part II. Other significant conditions cor	tributing to death but	not resulting in the	underlying cause	given in Part I.	23e. Did to	obacco use contribute to the	
of Vital Record	The law ate has b page 2 sl	Completed						24a. Was autop perfor	sy prior to co	psy findings available mpletion of cause of 2 \( \square\) No
Vita	Physician: T this certificat ral director, pa	Be	25. Was case referred to medical examiner?	lospital:			)thor	of Death (Check only or		
	Phys this ral di	. To	1X Yes 2 No 27. Manner of Death	28a. Date of Injury	28b. Time	BILL SCI DOA	4 🗀 1901		lence 6 Other (Specificow injury occurred	(y)
ion	Attending r death. actor: After by the funer	atlor	1 □ Natural 5 □ Pending 2 □ Accident investigation	Mor , Day	Year) Injun		lork? □Yes 2 <b>X</b> N	c /	red 8L51	-
Division	ii or Attendi after death. Diractor: A d in by the fu	Certification:	3 Suicide 6 Could not be determined	Place of Injury	y - At home, farm, (Specify)	street, factory, offic	:8	28f. Location (S City or Tow	Street and Number or Rura m, State)	al Route Number,
	pital or Al ours after o ieral Dirac filled in by			Fzz		street			400 BIK FS	TSE
	To tha Hospital or A within 24 hours after To the Funeral Dirac completely filled in by	edical		ner: On the basis of e	xamination and/or			h occurred at the time, o	ause(s) and manner as s date and place, and due to	
	To tha Hos within 24 h To the Fur completely	Med	29b. Signature and title of certifier	and manner state	30.	29c. Lice	nse number		284/200 29d. Date signed (Month,	Day, Year)
0	F 5 F 5		Merke	mpleted cause of dea	ath (Item 23a) (Tim		OCME		April 5, 2	2005
1	0		J. LARON LOCA	July)		111	Penn St	reet Balti	imore, Maryl	and 21201
*	Sta Registr		31. Date filed (Month, Day, Year) APR 1 1 2005		's Signature	who				
DH	MH 17 Bev 1/2	001		-						

State of Maryland / Department of Health and Mental Hygiene [] [] 5 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 2005 Apri1 2300 РМ Albert R. Mars, Sr. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 288 Baron Road North East Cecil If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) OCT 25, 194 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 1**X**) M 2□ F 25, Director 212-38-2485 64 1940 Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits 28a-f show the Mudical Examiner must be notified at 1 ☐ Yes 2 XNo Completed by Funeral Director Cecil Maryland North East 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 0 21901 238 288 Baron Road United States 12. Was Decedent Ever in U.S. Amed Forces? 1958-14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 21215-0036 5 1961 1 ☐ Yes 2 ☐ No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced White "natural", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) United States Hygiene. Elementary/Secondary (0-12) Coilege (1-4or 5+) Government P1umber or other traumatic avant, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Maryland permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 le marked oth any injury or othar traumatic avant 2008. Be Charles W. Mars Irene Collins 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Phyllis A. Meadows/Sister 6 Lyric Drive, Newark, Delaware 19702 Baltimore, 20b. Place of Disposition (Name of Apri $\overset{\text{Date}}{1}$  23, 20a. Method of Disposition 20c. Location - City or Town, State North East Methodist 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) North East, Maryland Cemetery 22. Name and Address of Facility Hicks Home for Funerals, P.A. 103 W. Stockton Street, Elkton, Maryland 21921 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each tine. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician Kenal Pallure /Medical Due to for as a consequence of **Examiner** Sequentially list conditions, any local process of the cause. Enter Underlying Cause (Disease or injury that initiated events Examiner physicien and s the burial-transit Physician: The law requires that the death certificate be executed Schemic resulting in death) Last Due to (or as a consequence of) Box 68760, Be Completed by Physician/Medical attending p *IF FEMALE* 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 2 Fetal death 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) P.0. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Huperlipidemia 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an obacco page 2 s autopsy performed? this certificate 2 \( \text{No}\) 1 Yes 2 🗷 No 1 Tes Vital 25. Was case referred to medical examiner? director 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 2 1 ☐ Yes 2 X No of After thi funeral of 28a. Date of tnjury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: Division To the Hospital or Attanding 1 Natural 5 Pending investigation s after dea. 1 ☐ Yes 2 ☐ No М 2 Accident 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a To the Funeral C 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number Lanter MD 30. Name and address of person who completed cause of death (item 23a) (Type, Print) 20 Craigtown Road-Suite 106, Part Deposit, MD 21904 Canter Karen L 31. Date filed (Month, Day, Year) 32. Benjitrar's Signature State Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Dorothy Nathanson April 6, 2005 6:45 A.M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Hebrew Home of Greater Washington Rockville Montgomery If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | March 12, 1915 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Birthplace (State or Foreign Country) **Funeral** Months Days 1 □ M 2 □ F Director 90 135-38-5500 New York Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits or 28a-f show Examiner must be notified at 1 ☐ Yes 2 ☐ No Directo Maryland | Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or items 23a 6121 Montrose Road 20852 U. S. A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after near of Health and Mental Hygiene.

ant: If item 27 is marked other than "naturel; or file ury or other treumatic svent, Ira Modical Examina 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ģ 1 ☐ Yes 2 📉 No Specify: Specify: White 3 Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Years Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Beatrice Meyerowitz Samuel Prager 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code20854Marc Nathanson - Son 12617 Orchard Brook Terrace, Potomac, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 X Removal from State permit. Page Department of Importent: If any injury or injury 4 ☐ Donation 5 ☐ Other (Specify) Cedar Park Cemetery 4-7-2005 Paramus, New Jersey 21. Signature of Funeral Service License, DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC. 1170 ROCKVILLE PIKE, ROCKVILLE, MARYLAND Donald ( 20852 attlemer 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition NEUMONIA **Physician** resulting in death) /Medical Due to (or as a consequence of): Examiner ORGANISM UNIDENTIFIED Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. the attending physicien Physiclan/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? detached for Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown á Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. been signed 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 □Unknown 1 Tes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has certificate 1 ☐ Yes 2 ☐ No 1 Yes the Hospitel or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only or Hospital: Other: Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ٩ 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 Pending 1 Natural death. 1 ☐ Yes 2 ☐ No s 24 hours after death is Funerel Director; A letely filled in by the fo 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide 29a. Certifie Ty Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 To the I 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) T MONTROSE State mile Registrar

NATHANSON

			_ F0I	artment of Health and Mer	ntal Hygiene	11241 000					
	Physici	20	1. Decedent's Name (First, Middle, Last)	-	Date of Death Month Da	3. Time of Death  Year					
	Physici /Medic		Cherry Yvonne Nance			2005 Year 5:50a M					
1	Examin	er									
			6801 Coolridge Road  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	If I Index 1 Veer   If I Index 24 Hrs   n	filloder 1 Veer   If I loder 24 Hrs   a Dear of Dist						
	Funeral Director		578-58-6340 1 M 2 F 59 Yrs.	Months Days Hours Min.	(Month, Day, Year, 19	9. Birthplace (State or Foreign Country) Washington, DC					
			Usual Residence of Decedent								
	how how		10a. State 10b. County 10c. City, Town or I	ocation		10d. Inside City Limits					
	Ba-f.s	cto	Maryland   Prince George   Temple Hi	11s		1 X Yes 2 ☐ No					
	ith th	Dire	10e. Street and Number	10f. Zip Code	10g. Ci	itizen of What Country?					
	ath w	rai	6801 Coolridge Road	20748	Uni	ted States					
	er de	une	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?	Was Decedent of Hispanic Origin? (Specify If Yes, specify Cuban, Mexican, Puerto Ric	y Yes or No- an, etc.)	<ol> <li>Race - American Indian, Black, White, etc.</li> </ol>					
36	I', or	by Funeral Director	1 □ Never Married 2 1 Married 1 □ Yes 2 1 No If Yes, Give 3 □ Widowed 4 □ Divorced Year or Dates:	1 ☐ Yes 2 👿 No Specify:		Specify: Black					
215-0036	within 72 hours after death with the Maryland ene. than "netural", or Items 23a or 28a-f show fra Modical Excriber must be notified at	ted	15. Decedent's Education 16a. Dec	edent's Usual Occupation	16b. K	Cind of Business/Industry					
215	hin 7	Completed	(Specify only highest grade completed) (Giv Elementary/Secondary (0-12) College (1-4or 5+)	e kind of work done during most of working DO NOT use retired)							
7	er th	Con	12th Hous	ewife		estic					
pu	12 should be filed within ? h and Mental Hygiene. 7 is marked other than "! traumatic event, It'e M.	Be	17. Father's Name (First, Middle, Last)	18. Mother's Name (F		n Surname)					
yla	Menda Menda	2	James E. Walker		icas	as Town Chata Tin Code)					
Maryland	d 2 st th and 7 ts n traun			ling Address (Street and Number or Rural R Coolridge Road Temp	-						
	1 an Heal tem 2		20a Method of Disposition 20b. Place of Disp	osition (Name of Date		ocation - City or Town, State					
OF.	ages ant of nt: If i		1 Burial 2 Cremation 3 Removal from State	Veteran Cem. 4-13-0	of Chai	ltenham,Maryland					
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importants if item 27 is marked other than "netural", or Items 23a or 28a-1 show Importants if item 27 is marked other than "netural", or Items 23a or 28a-1 show any injury or other traumatic event, Ite Marical Examiner must be natified at ODGs.			2. Name and Address of Facility Alexander S. Pope Fu							
m	Depa Depa Impo eny ir		Vrutte KV/100	5538 Marlboro Pike B	orestvil	1e,Md 20747					
	Physician		23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.	nter the mode of dying, such as cardiac or re	espiratory arrest,	Approximate Interval Between					
			Immediate Cause (Final disease or condition Rheumatoid Arth	ritis		Onset and Death					
	/Medical Examiner		Due to (or as a consequence of):								
		-	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):								
	uted I Insit	Examiner	cause. Enter Underlying Cause (Disease or injury								
Ć,	certificate be executed iding physician and ise as the burial-transit	Exa	that initiated events c.  resulting in death) Last  Due to (or as a consequence of):								
8760,	cate be ohysicia the bu	icai	d								
9	eath certifical attending phy i for use as th	ed	IF FEMALE:								
Вох	th ce tendi	an/I	23b. Was decedent pregnant in the past 12 months?	□Ectopic pregnancy		23d. Date of delivery  Month Day Year					
	t the dea by the a lached fo	Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 5 9 ☐ Unknown	Other (specify)		,					
P.0	that the		Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacco	use contribute to the cause of death?					
Records,	equires that sen signed by could be deta	d by			1 □ Yes 2	No 3 Probably 4 Unknown					
CO	× 2 7	Completed			24a. Was an	24b. Were autopsy findings available prior to completion of cause of					
Re	The lav ate has page 2	отр			autopsy performed?	death?					
tal	aicien: Th certificate rector, pag	O	25. Was case referred to medical	26. Place of Death (C	1 ☐ Yes 2 🔀 No Check only one)	0 10163 20110					
Ž	d is	To B	examiner? 1 Yes 2 No  Hospital: 1 Inpatient 2 ER/Outpati	ent 3 DOA Other: 4 Nursing Home	5X Residence	6 ☐Other (Specify)					
0 4	ding Ph h. After th funeral		27. Manner of Death 18. Natural 5 Pending (Month, Day Year) 28a. Date of Injury (Month, Day Year) 19. Injury	Work?	d. Describe how inju	iry occurred					
sio	ttending death. tor: After the funer	cati	2 Accident investigation	M 1 ☐ Yes 2 ☐ No	1						
Division of Vital	or At after d Direct in by	Certification:	4 Homicide  4 Homicide  4 Homicide  4 See. Place of Injury - At home, farm, so building, etc. (Specify)	treet, factory, office	City or Town, Stat	nd Number or Rura I Route Number, re)					
	ospitel hours a unerel I	i Ce	29a. Certifier 1 <sup>™</sup> Certifying Physician: To the best of my knowledge, dea	ith occurred at the time, date and place, and	I due to the cause(s	s) and manner as stated.					
	To the Hospitel or Attenwithin 24 hours after deatl To the Funerel Director:	edical	(Check only one) 2 Medical Examiner: On the basis of examination and/or and manner stated.								
	Taithing of the state of the st	Me	29b. Signature and title of certifier	29c. License number	29d. Da	ate signed (Month, Day, Year)					
	(5)	(5) D35206 April 7, 2005									
6	70		30. Name and address of person who completed cause of death (Item 23a) (Type	•	_1_1	W1 207//					
To the	<u> </u>		William T. Tanner, M.D. 11701 Li	vingston Rd. Ft. Was	snington,	Md. 20744					
	Sta Regist		APR 1 2 2005								
DI	IMH 17 Rev 1/2		January Jan	See Control of the Co							

DHMH 17 Rev 1/2001

O5-02725 RKD

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1- State of Maryland / Dep State of Maryland / Dep Registrar 23a-b,pt.II,27 per Ce	artment of Health and M me. G842 4-28-05 ta rtificate of Death	Mental Hygie	ene 3.2005 14212						
	Physici		Decedent's Name (First, Middle, Last)     SUSAN GAIL NOOTENBOOM	2. Date of Death APRIL	3. Time of Death 18, 2005 2:53P. M							
	/Medic Examir		4a. Facility Name (If not institution, give street and number) 12811 LOCKBURY CIRCLE	4b. City, Town, or Location of Death GERMANTOWN		4c. County of Death MONTGOMERY						
503	Funeral Director		5. Social Security Number  219-82-3104  6. Sex 1 M 2 F 7. Age (In yrs. last birthday 43 Yrs.	If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, ) Nov. 6,	Year) 9. Birthplace (State or Foreign Country) 1961 Maryland						
	be filed within 72 hours after death with the Maryland tal Hygiene. d other than "natural", or items 23a or 28a-f show event, the Madical Examiner must be notified at	al Director	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or L  Maryland Montgomery Germant  10e. Street and Number  12811 Lockbury Circle		100	10d. Inside City Limits 1 □ Yes 2 □ No  g. Citizen of What Country?  20874						
920	urs after des at', or fems Examiner m	by Funeral	11. Marital Status  1 X Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 Yes 2 X No If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☒ No Specify:	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White						
Maryland 21215-0036	s within 72 hou piene. r than *nature the Medical E	Completed	(Specify only highest grade completed) (Given Elementary/Secondary (0-12) College (1-4or 5+)	dent's Usual Occupation I kind of work done during most of work DO NOT use retired)	ing 16	6b. Kind of Business/Industry						
rland 2	should be filed withind Montal Hygiene. It marked other than umatic event, the M	ro Be Co	17. Father's Name (First, Middle, Last)  John Larry Nootenboom		e (First, Middle, Ma							
Baltimore, Mar	permit. Pages 1 and 2 should be l Department of Health and Mental I Important: If item 27 is marked o any injury or othar traumatic eve once.		John L. Nootenboom - Father  20a. Method of Disposition  1 Burial 2 Cremation 3 Removal from State  4 Donation 5 Other (Specify)  21. Signa ure of Juneral Service Licensee	matory or other place)	ff Dr., 7	Tucson Arizona 85739 De Location - City or Town, State Lexandria, Virginia						
	Physician /Medical Examiner		23a. Part1. Enter the disease, or complications that caused the death. Do not enshock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Acute Pancreatitis  Due to (or as a consequence of):  Chronic Alcohol Abo	5401 Ridge Road, D ter the mode of dying, such as cardiac o								
8760,	cate be executed physician and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  d.									
P.O. Box 6	that the death certific ed by the attending pi detached for use as t	Physician/Me		⊒Ectopic pregnancy ⊒ Other (specify)		23d. Date of delivery Month Day Year						
	w requires that been signed b should be deta	by	Part II. Other significant conditions contributing to death but not resulting in the u  Cocaine use	nderlying cause given in Part I.		cco use contribute to the cause of death?						
Vital Records,	iclan: The law certificate has b ector, page 2 sl	e Completed	25. Was case referred to medical	26. Place of Double		24b. Were autopsy findings available prior to completion of cause of death?  No 124 Yes 2 No						
Division of Vi	tending Physicath.  tor: After this the funeral dis	Certification: To Be	1 XYes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) SCENT									
۵	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	Medical Cer	29a. Certifier  (Check only one)  Check only one)  (Check only one									
	To the within 2 To the complete	Me	29b. Signature and title of certifier  Common Pouls	29c. License number  OCME		Date signed (Month, Day, Year) RIL 19,2005						
	Sta Registi	100	30. Name and address of person who completed cause of earth (Item 23a) (Type, ATR 2 6 2005	Print) 111 Penn Stre	et Balti	imore, Maryland 21201						
DH	MH 17 Rev 1/2	001	ORIGINA	AL								

			1 - State of Maryland / Departr State Certifi	nent of Health and N cate of Death		iene 0 0 5	14213				
	Physici		Decedent's Name (First, Middle, Last)     BETRYCE GOLDREICH PROSTERMAN		2. Date of Deat Month APRIL	Day Year	3. Time of Death 8:38 P <sup>M</sup>				
	/Medic Examin		4a. Facility Name (If not institution, give street and number)  4b	4c. County of Deat							
			CASEY HOUSE	TION 2							
	Funeral Director		075-07-9794 1□M 2X□F 87 Yrs. MG	Under 1 Year   ff Under 24 Hrs. onths Days Hours Min.	8. Date of Birth (Month, Day, 06-26-	9. Birti -1917	nplace (State or Foreign untry) IL				
	land ow		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location	n			10d. Inside City Limits				
	Many a-fsh ified	tor	MD MONTGOMERY CHEVY CHAS	SE			1 X Yes 2 No				
	or 28	Director	10e. Street and Number	Of. Zip Code	1	0g. Citizen of What Co	untry?				
	s 23a	ral	5630 WISCONSIN AVE. #305	20815		USA					
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importants: if item 27 is marked other than "natural", or items 23a or 28a-f show many july or other traumatic event, the Medical Examinar must be notified at ODGs.	by Funeral	1 Never Married 2 Married 1 Yes 2 X No	Decedent of Hispanic Origin? (Sp. specify Cuban, Mexican, Puerto 4es 2 🛣 No Specify:	pecify Yes or No- p Rican, etc.)	14. Race - Ame Black, White Specify: WH]	e, etc.				
21215-0036	2 hou	ted	15. Decedent's Education 16a. Decedent'	s Usual Occupation	1.:-	16b. Kind of Business/	industry				
215	ithin 7	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	of work done during most of work IOT use retired)	King						
	lled w tygier har th	Cor	2 ARTS AI  17. Father's Name (First, Middle, Last)	OMINISTRATOR 12 Market No.	- (First 16:44)	PRIVATE					
and	d be fantal h	o Be	JULIUS GOLDREICH	ANNA	ne (First, Middle, M N	IICHAELS					
Maryland	shoul nd Me mark	To		ddress (Street and Number or Ru			Tip Code)				
	and 2 alth a 27 is			34TH PLACE, NW,							
Baltimore,	Pages 1 and the pages 1 and th		20a. Method of Disposition  1 🛣 Burial 2 □ Cremation 3 □ Removal from State  1 □ Donation 5 □ Other (Specify)  20b. Place of Disposition cemetery, cremato  MT • LEBANON	ry or other place)	Date :	ADELPHI,					
Balt	permit. Departr Importa any inju		21. Signature of Funeral Service Licenses  Commanda Madeura 22. Na EDWA 1091	me and Address of Facility ARD SAGEL FUNERA ROCKVILLE PIKI	AL DIRECT	TION, INC.	852				
	Physician	8 17	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the shock, or heart failure. List only one cause on each tine.  Immediate Cause (Final disease or condition METASTATIC CARCINON a METASTATIC CARCINON A METASTATICAL A	e mode of dying, such as cardiac			Approximate Interval Between Onset and Death MONTHS				
	/Medical Examiner		resulting in death)  Due to (or as a consequence of):	14.1			MONTHS				
	zxammer	<u>.</u>	Sequentially list conditions, if any, leading to immediate b. NON SMALL CELL LUNC	CANCER			YEARS				
	nted nsit	mine	if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):								
Ć,	ificate be executed g physician and as the burial-transit	Examiner									
68760,	ate be nysicia ne bur	edical	d								
_	i oo ii		IF FEMALE:								
.O. Box	death e atter	by Physician/M	23b. Was decedent pregnant in the past 12 months?	opic pregnancy er (specify)		23d. Date of deli Month	very Day Year				
s, P	requires that the reen signed by th hould be detache	y Pt	Part II. Other significant conditions contributing to death but not resulting in the under	lying cause given in Part I.	23e. Did tob	acco use contribute to	the cause of death?				
rds	w requires tha s been signed I should be det	ed b			1 <b>∑</b> Ye	s 2□No 3□Pro	obably 4 □Unknown				
Vital Record	The law ate has b page 2 s	Completed			24a. Was ar autops perform 1 Yes 2	y prior to death?	topsy findings available completion of cause of				
/ita	Physician: Th this certificate ral director, pag	Be (	25. Was case referred to medical examiner?		th Check on one						
of	Physi this c	-T	1 ☐ Yes 2 🗶 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3  27. Manner of Death 28a. Date of Injury 28b. Time of		ome 5 Reside	nce 6X Other (Spec	HOSPICE				
	ding h. After funer	tlon	1 X Natural 5 ☐ Pending (Month, Day Year) Injury	28c. Injury at Work?  1 □ Yes 2 □ No	280. Describe no	winjury occurred					
Division	Attending r death.	ifica	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street,		28f. Location (St	reet and Number or Ru	ral Route Number,				
Ö	s after s after ai Dire	Certification;	4 ☐ Homicide building, etc. (Specify)		City or Town	, State)					
	To the Hospital or Attending Physician: within 24 hours after death. To the Funaral Director: After this certific completely filled in by the funeral director.	edical	29a. Certifier (Check only ane)  1 Certifying Physician: To the best of my knowledge, death occ 2 Medical Examiner: On the basis of examination and/or investigand manner stated.	surred at the time, date and place, gation, in my opinion, death occur	, and due to the ca rred at the time, da	iuse(s) and manner as ate and place, and due	stated. to the cause(s)				
	To the To tha complet	Σ	29b. Signature and title of certifier	29c. License number	25	d. Date signed (Month	, Day, Year)				
(	5)		) E. P. Libré n D	D09470		APRIL 10,	2005				
	i3		30. Name and address of person who completed cause of death (Item 23a) (Type, Prini EUGENE P. LIBRE, M.D., 10901 CONNECTICU	T AVENUE, KENS	INGTON, M	D 20895					
	Sta Registi		31. Date filed (Month, Pax, Yaar) 2 2005 32. egistrar's Signature	lu							

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** April 9. 2005 9:15 A Basil Bernard Phillips /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Montgomery Holy Cross Rehabilitation & Nursing Burtonsville If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** Months 1**∏**M 2□F Director 79 Sep. 22, 1925 Alabama 229-80-1784 Usual Residence of Decedent 10d Inside City Limits Maryland 10c. City. Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "natural", or Items 23a or 28a-1 show any injury or other traumatic avent, the Medical Examination that be notified at once. 10b. County 1 ☐ Yes 2 ☑ No Director Adelphi Prince George's Maryland | 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20783 IISA. Funerai 1733 Metzerott Road Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☑ Never Married 2 ☐ Married 1 ☐ Yes 2K No Specify: Specify: Baltimore, Maryland 21215-0036 Completed by White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Religious Missionary Br<u>other</u> 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Unknown **Phillips** Unknown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Supervisor 1733 Metzerott Road Adelphi, MD 20783 Richard McCann, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Holy Trinity 20c. Location - City or Town, State Date 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 X Removal from State Trinity Cemetery Apr.13,2005 Mitchell, Alabama 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Francis J. Collins Funeral Home, Inc. 500 University Blvd., W., Silver Spring, MD 20901 elling 23a. Part. Enter the disease, or complications that daused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Old Age, General Deconditioning Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Chronic Obstructive Pulmonary Disease Sequentially list conditions, if any, leading to inimediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner or Attending Physician: The law requires that the death certificate be executed burial-transi Due to (or as a consequence of): Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE 23d. Date of delivery 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel death 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown o the 5 ۵ 23e. Did tobacco use contribute to the cause of death? signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 Yes 2X No 3 Probably 4 Unknown Dementia Completed peeu 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Malnutrition autopsy performed? page 2 2**⊠** No 1 Yes 1 Yes certificate 25. Was case referred to medical examiner? 26. Place of Death (Check on one Be Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 🗶 No Medical Certification: To 28c. Injury at Work? 28d. Describe how injury occurred funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death After 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No М investigation within 24 hours after death.

To the Funeral Diractor: A completely filled in by the fu death. 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier M.D DO052861 April 11, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Asha Vail, M.D. PRING
9801, GEORGIA ANENUE, SILVER SPRING Registrar's Signature 31. Date filed (Month State Registrar

			For State Registrar	State of Ma		d / Depa		of He	ealth a		ental Hy		005	142	5
	Physicia	an	Decedent's Name (First, Middle, Last)								2. Date of De Month	ath Day	Year	3. Time o	of Death
	/Medic		SAMUEL PAPICH, S								April	06	2005		) A <sup>M</sup>
	Examin	er	4a. Facility Name (If not institution, give	street and number)			4b. City, To	own, or i	Location o	of Death		4c.	County of De	ath	
			Holy Cross Hospi						Spri				Montgo		
П	Funeral		5. Social Security Number 6. Security Number 1589.16.0361	( 7. Age ∄M 2□F	83 (In yrs. Ia	st birthday) Yrs.	If Under 1 Months	Days	If Under :	Min.	8. Date of Bir (Month, Da	th y, Year)	9. B	rthplace (State country)	or Foreign
	Director		Usual Residence of Decedent		03					¥	Aug.7,	1921	Pe	nnsy1va	nia
	/land		10a. State 10b. County		10c. City,	Town or Lo	cation							10d. Inside C	City Limits
	Mar-f st	to	Maryland Montgome	ry	Si	lver S	bring							1 X Yes	s 2 No
	r 28s	irec	10e. Street and Number				10f. Zip C	Code				10g. Citi	zen of What (	Country?	
	23a c	aD	1315 Caddingston	Avenue			20	901				U	S.A.		
	ams arms	ner	11. Marital Status	12. Was Decedent E Armed Forces?	ver in U.S	13.	Was Decede	ent of His	panic Orig	gin? (Spe	cify Yes or No Rican, etc.)	)-	14. Race - An Black, Wh	erican Indian,	
9	or It	by Funeral Director	1 ☐ Never Married 2 📆 Married	1 🔀 Yes 2 🗆 N If Yes, Give	lo WW		1 ☐ Yes 2		Specify:				Specify: W		
ë	within 72 hours after death with the Maryland ene. Than "natural", or Itams 28a or 28a-f show he Medical Examinar must be notified at	q p	3 Widowed 4 Divorced	Year or Dates:	II										
5	"nat	Completed	15. Decedent's Edu (Specify only highest grad	cation e <i>completed)</i>		16a. Deced	dent's Usual kind of work DO NOT use	Occupat done du	tion <i>uring m</i> ost	t of workir	ng	16b. Ki	nd of Busines	s/Industry	
7	within ene. than	m d	Elementary/Secondary (0-12)	College (1-4or 5	+)		ick la					M.	asonry		
0	filad Hygi other	Ö	17. Father's Name (First, Middle, Last)				TCK TO	1	18. Mothe	r's Name	(First, Middle				
an	id be ental ked c	To Be	George Papich						Mar	rie	Burchi	ck			
Maryland 21215-0036	shound M	-	19a. Informant's Name/Relationship (Ty	rpe, Print)		19b. Mailir	ng Address (	Street au	nd Numbe	er or Rura	Route Numb	er, City o	r Town, State,	Zip Code)	
Š	elth a		Ann M. Papich/Wif	e		1315	Caddi	ingst	ton A	venu	e, Sil	ver :	Spring	MD 209	901
ē,	of Herm		20a. Method of Disposition		20b. Pla	ace of Dispo	sition (Name	e of ner place	)	D	ate	20c. Lo	cation - City o	r Town, State	
Ë	Page Int: If		1 ☑ Burial 2 ☐ Cremation 3 ☐ F  1 4 ☐ Donation 5 ☐ Other (Specify)	ternoval from State	1		Heaver		m. C	)4/09	/2005	Silv	er Spr	ing, Mar	ry1and
Baltimore,	permit. Pagas 1 and 2 should be filad within 72 hours after death with tha Marylan Department of Heelih and Mental Hygiene. Important: If Item 27 is marked other than "natural; or Itams 23a or 28a-f show amportant: If Item 27 is marked other than "natural; or Itams 23a or 28a-f show injury or other traumatic event, the Madical Examinat must be notified at 2008.		21. Signature of Funeral Service Licens	9	,	22	2. Name and	Address	of Facilit	y HINED	AL HOM	C T.	IC.		
<u>m</u>	89 = 29		Nancy A.	Vercon	مر	<u>                                     </u>	1800 N	lew F	lamps	hire	Ave, S	Silve	er Spri	ng, MD	20904
П			23a. Part1. Enter the disease, or compl shock, or heart failure. List only or	ications that caused ne cause on each lin	the death.	Do not ent	er the mode	of dying	, such as	cardiac o	r respiratory a	rrest,		Approxima Interval Be	tween
E	Physician :	9	Immediate Cause (Final disease or condition	Cardiac										Onset and Termin	
	/Medical		resulting in death)	Due to (or as	a consequ	ence of):									
	Examiner		Sequentially list conditions.	Coronar			sease							10 yea	ars
	sit ad	ine	Sequentially list conditions, if any, leading to immediate cause (Disease or injury	Due to (or as	a consequ	ence of):								1	
	and and I-tran	Examiner	that initiated events resulting in death) Last	Due to (or as a	a conseque	ence of):								-	
760,	ate be executed hysician and the burial-transit	icai E													
687	ficate physics the			J											
×	leath certifical attending phy I for use as th	N N	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome									23d. Date of d	elivery	
ă	death e atte d for	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 4 ☐ Pregnant at			]Ectopic pred ] Other (spec						Month		Year
Ö	that the de ned by the a detached f	Physician/Med	9 Unknown	9□Unknown											
Records, P.O. Box	The law requires that the death certifice the has been signed by the attending phoage 2 should be detached for use as it.	by P	Part II. Other significant conditions con	ntributing to death bu	ut not resul	Iting in the u	nderlying cau	use give	n in Part I.		23e. Did t	obacco u	se contribute	to the cause of	death?
ğ	w require been sig		Congestive Heart	Failure							10	Yes 2	XINo 3□I	Probably 4 🗌	Unknown
000	law re as be 2 sh	pie									24a. Was		24b. Were	autopsy findings completion of	available
č		Completed									perfo	rmed?	death?	s 2 No	oause of
Vital	Physician: The lav this certificate has ral director, page 2	Be	25. Was case referred to medical examiner?								(Check only	one)	1		
Ž	hysic his ce Il dire	2	1 ☐ Yes 2 🔀 No	lospital: 1 ☐ Inpatie			nt 3□ DOA	Other	r: 4 🗆 Nu	irsing Hon	ne 5 🗆 Resi	dence (	6 □Other (Sp	ecify)	
ח	ing P	on:	27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date of Injur (Month, Day	Year)	28b. Time of Injury		c. Injury Work			28d. Describe	how injur	y occurred		
Sio	Attending ir death. ector: After by the fune	cati	2 Accident investigation 3 Suicide 6 Could not be				М		es 2 🔲		06 1	·			
Division of	or All	Certification;	4 Homicide determined	28e. Place of Inju- building, etc	S. (Specify)	ne, rarm, str )	eet, ractory,	опісе		2	City or To			Rural Route Nur	nber,
_	Hospital 24 hours a Funeral I		29a. Certifier 1 🛱 Certifying Phy	sician: To the best of	of my know	viedne deatl	b occurred at	t the time	e date an	d place a	and due to the	causa(s)	and manner	as stated	
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medicai	(Check only 2 Medical Exami	ner: On the basis of and manner sta	examinati	on and/or in	vestigation, i	in my opi	inion, dea	th occurre	ed at the time,	date and	place, and di	ie to the cause(	s)
	To ths within 2 To the complet	Me	29b. Signature and title of certifier	1			29c.	License	number			29d. Dat	e signed (Moi	nth. Day, Year)	
	> - 0		Deoron Ux	Jenan	a 14	m	D,	D-12	2121			Anı	ri1 7,	2005	
	1		30. Name and address of person who co	ompleted pause of d	eath (Item	23a) (Type,						P-			
	5		Geo Fleming Sen	gstack, M	.D.,	3929	Ferrar	a Dı	rive,	Whe	aton, 1	Mary1	Land 20	906	
	Sta Registi		31. Date filed (Month Par Yar) 2 2	005 32. egistra	ar's Signati	B A	sole								
	, region			1	-	-/									

		•	For State Registrar	State o	f Marylan		artment of lateriticate of			lental I		ene ()	35	14216
45	/val		Decedent's Name (First, Middle,	Last)						2. Date o			.,	3. Time of Death
	Physici		Cynthia R. P	arker						April		Day	Year	3:42PM
	/Medic Examin	4	4a. Facility Name (If not institution,		mber)		4b. City, Town,	or Location	of Death	17pru			y of Death	
	Examin	er	Doctor's Commu				Lanham					Princ	e Ge	orge's
	Former			6. Sex	7. Age (In yrs. i	last birthday)	If Under 1 Year	If Under	24 Hrs.	8. Date o	Birth			pface (State or Foreign untry)
	Funeral Director		006-16-1997	1 □ M 2 🖔 F	83	Yrs.	Months Days	Hours	Min.	Jan.	, Day, Y			intry) York
		-	Usuaf Residence of Decedent							Jan.	10,	1,722	New	TOTK
	ow is		10a. State 10b. County		10c. City	y, Town or Lo	cation							10d. Inside City Limits
	Man,	to	MD Prince	George's	Mit	chelly	7ille							1∭XYes 2 ☐ No
	28a	Director	10e. Street and Number	ocorge .	, ,,,,,,	CHCII	10f. Zip Code				100	g. Citizen of	What Co	intry?
	with		10450 Lottsford	Pond #20	116		207	21				USA		
	d within 72 hours after death with the Maryland plene. I the Medical Examiner must be notified a	Funeral	11. Marital Status		edent Ever in U.	S. 13.			igin? (Sp	ecify Yes o	r No-		ice - Amer	ican Indian,
	Iten	5	1 ☐ Never Married 2 ☐ Marri	Armed Fo	orces?		Was Decedent of f Yes, specify Cul	ban, Mexica	n, Puerto	Rican, etc.	)	Bfa	ack, White	, etc.
36	irs af	by	3 X Widowed 4 □ Divorced	If Yes, Gi Year or D	ve		1⊡Yes 2XX No	Specify	:			Spec		nite
21215-0036	hou	ed	15. Decedent	s Education		16a, Dece	dent's Usuaf Occu	pation			16	6b. Kind of I		
15	in 72	Completed	(Specify only highes	t grade completed)		/Give	kind of work done DO NOT use retire	durina mos	st of work	ing				,
12	with thar	E	Elementary/Secondary (0-12)	College (	1-40r5+)	Tead	cher					Sidwel	11 Fr	iends
0	e filed within al Hygiene. I other than '		17. Father's Name (First, Middle, I					18. Moth	er's Name	e (First, Mi	ddle, Ma	aiden Suma	me)	
Maryland	s 1 and 2 should be filed f Health and Mental Hyg item 27 is marked othe other treumatic event,	o Be	Eustace Reynold	C				F145	ahat	h Wal	hri	anh		
$\leq$	2 should be and Mental is marked (	10	19a. Informant's Name/Relationsh			19b. Maili	ng Address (Stree						n. State. Z	io Code)
<b>≥</b>	d 2 s th ar t7 ts treu		Diana Parker, I				aples C							,
	of Health item 27 i		20a, Method of Disposition	augnter	20b. P	face of Dispo	sition (Name of			Date				Town, State
ğ			1 ☐ Burial 2 XI Cremation		State	emetery, crea	natory`or other pl	ace)					-	
altimore,	tmer tent		'4 Donation 5 Other (Sp. 21. Signature of Europeal Service I		Met		n Cremato			2005				Virginia
Bal	permit. Page Department of Importent: If any injury or once.		21. Signature of Euneral Service I	liconsee			2. Name and Add						-	
	40244		alunt / lan	1/100	10137								iie,	Maryland
П	Physician /Medical Examiner		23a. Part1. Enter the disease, or shock, or heart failure. List	only one cause on	each line.	n. Do not en	er the mode of dy	ring, such as	s cardiac	or respirato	ry arres	π,		Approximate Interval Between Onset and Death
			Immediate Cause (Final disease or condition	-a ('Q	rollar	lan	upona	94						Ondot and Boatt.
			resulting in death)	Due to	(or as a conseq	uence of):	W.	10	4.		0	To		
п		,	Sequentially list conditions,	b. 2000	nomico	is r	enplur	ed u	son	pery	we	rexy		
	D ==	iner	if any leading to immediate	ot eu <b>Q</b>	(or as a conseq	uence of):	•			U				
	acute ind trans	Examin	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	,									
0	e exe ian a urial-	Ĕ	lesolling in death) Last	Due to	(or as a conseq	uence of):								
8760,	cate be executed physician and the burial-transit	dicai		d										
9	ing p	0	fF FEMALE:											
Вох	eath certifi attending   I for use as	an/	23b. Was decedent pregnant in the past 12 months?		utcome of pregna birth 2  Feta		Ectopic pregnan	су					ate of defi	very Day Year
	ed for	sici	1 ☐ Yes 2 🔀 No	4□Preg 9□Unkr	nant at time of d	leath 5[	Other (specify)				-	19	TOTAL	Day Tour
P.0	The law requires that the death certificate has been signed by the attending lage 2 should be detached for use as	Physician/M	9 Unknown										-	
	es tha igned be de	by	Part If, Other significant condition	A			inderlying cause g	liven in Part	I.			_		the cause of death?
ord	w requir been si should	ed	home no	one w	eurys	170					1 ∐ Yes	2 □ No	3 🗆 Pro	bably 4x Unknown
Records,	aw re	pie	Colon Cano	er his	(ong						Was an	24b	. Were au	topsy findings available completion of cause of
Ä	The lav	Completed	hubertons	nov						102	erforme	ed? □ No	death?	2 No
Vital		a a	25. Wars case referred to medical		,			26. Plac	e of Deat	h (Check o				
>	Physiclen: this certific ral director,	0 8	exammer? 1 ☑ Yes 2 ☐ No	Hospital:	Inpatient 2	ER/Outpatie	nt 3 DOA	ther: 4 🗆 N	lursing Ho	ome 5 🗆	Residen	ice 6 🗆 O	ther (Spec	cify)
of		П: Н	27. Manner of Death	28a. Date	of injury oth, Day Year)	28b. Time o						v injury occu		
o	nding F tth. :: After e funera	atio	1 ENatural 5 ☐ Pendin 2 ☐ Accident investi	9	noi, Day 1 ear)	Injury		Yes 2	]No					
Division	l or Attending after death. Director: After in by the fune	ifica	3 Suicide 6 Could determined	ined   286. Place	e of Injury - At h	ome, farm, st	reet, factory, office	9					nber or Au	ral Route Number,
ā	after after Direct	Certification:	4   Homicide	Duile	ding, etc. (Special	(y)				City	r Town,	States		
	Hospite 24 hours Funeral etely filled	aic	29a. Certifier 1 Certifyir	g Physician: To th	e best of my kno	owledge, dea	th occurred at the	time, date a	nd place,	and due to	the cau	use(s) and r	nanner as	stated.
	e Ho e Fu letely	Medical	(Check only 2 Medical one)	Examiner: On the	basis of examina nner stated.	ation and/or ir	ivestigation, in my	opinion, de	ath occur	red at the t	ime, dat	te and place	e, and due	to the cause(s)
	To the Hospitel or At within 24 hours after or To the Funeral Direct completely filled in by	Me	29b. Signature and title of certife	10	-		29c. Lice	nse number			29	d. Date sign	ed (Monti	n, Day, Year)
			1	NOW	1		nn n	0603	39		1	04 0	5/2	2005
1	(10)		30. Name and address of person	who completed car	use of death (Iter	n 23a) (Type			- 1					
L	10/		I de las A i s	100 Goodly				md.	Ann	4				
1	St	ate	31. Date filed (Month, Day, Year)	12.	Registrar's Signa	ature	-cirium	1101 0	0 100					
	Regist		APR 1 2 2	005	Registrar's Signa	dos	de la							

PARKER CYNTHIA

			For	State of Maryl	and / Depa	artment of H	lealth a	nd Me	ntal Hyg	iene,	000	11.01*7
		_ 1	State Registrar		Cei	rtificate of l	Death		R	eg. No.	CUU	14611
	Physicia		1. Decedent's Name (First, Middle, Last)					2	. Date of Deal Month	th Day	Year	3. Time of Death
	/Medic	al -	Stanley Petty			4b. City, Town, or	Location of	Death	APKIL.	-	2005 ounty of Death	8:504M
	Examin	er	4a. Facility Name (If not institution, give					Doain			ince Ge	
	Funeral		Doctor's Communication 5. Social Security Number 6.	7. Age (In	yrs. last birthday)	Lanham If Under 1 Year Months Days	If Under 2	4 Hrs. 8	Date of Birth (Month, Day ULY 3,	Year)	9. Birth	plece (State or Foreign
	Director		217 12 9000	M 2□F 73	Yrs.	WOTHING Days	710013	J	uly 3,	193	l Gaff	ney, S.C.
	and *	}	Usual Residence of Decedent  10a. State 10b. County	100	. City, Town or Lo	ocation						10d. Inside City Limits
	Maryl f sho	to	Maryland Prince Ge	eorge's	Capitol	Heights						1 No 2 No
	h the	lrec	10e. Street and Number			10f. Zip Code			1	0g. Citize	on of What Co	untry?
	23a c	Funeral Director	1123 Jansen Ave.			2074					ited St	
	terna Terna	nue	T. Marian Grates	12. Was Decedent Ever Amped Forces? 1   Yes 2  No	in U.S. 13.	Was Decedent of H If Yes, specify Cuba	ispanic Orig In, Mexican,	in? (Speci Puerto Ri	fy Yes or No- can, etc.)	12	Black, White	, etc.
39	within 72 hours after death with the Maryland ene. than "natural", or Itema 23a or 28a-f show tha Madical Examinat nast be notified at	by F	1 ☐ Never Married 2 ☐ Married 3 🏝 Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 Ho	Specify:			5	Specify: B1	ack
2-0	72 hou natura	ted	15. Decedent's Edu (Specify only highest grad	cation e completed)	16a. Dece	dent's Usual Occup kind of work done DO NOT use retired	ation during most	of working	7	16b. Kind	of Business/I	ndustry
21	Aithin ne.	Completed	Elementary/Secondary (0·12)	College (1-4or 5+)		DO NOT use retired ilding Ma				Fede	eral Go	vernment
, D	filed withi Hygiene. other than ent, the M		17. Father's Name (First, Middle, Last)					's Name (	First, Middle,	Maiden S	umame)	
<u>a</u>	lid be lental ked o	To Be	Stanley Petty, Si	· •			Ira	a Ran	kins			
Maryland 21215-0036	2 should and Men is marke aumatic		19a. Informant's Name/Relationship (T)	rpe, Print)	19b. Maili	ng Address (Street	and Number	r or Rural I	Route Number	r, City or	Town, State, Z	îp Code)
	1 and 2 Health Iem 27 other tra		Katherine Petty		nter 145		d. Ply	mout			Pa. 19	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Itema 23a or 28a-f show any injury or other traumatic event, the Medical Examinat must be notified at once.		20a. Method of Disposition 1	Removal from State	cemetery, cre	matory or other place Memorial	ce)	4/13/			Land, M	
Itin	artmer artmer ortant injury		*4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service Lices			<sup>2</sup> Almeria Adie						
Ba	Depar Impo any ir		Prototologo	2010 M 010	35	5538 Mar	1boro	Pike	/Fores	tvil]		20747
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	lications that caused the ne cause on each line.	death. Do not en	ter the mode of dyir	ng, such as o	cardiac or	respiratory arr	rest,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition	Meta	itatin	Prosto	te	CARI	Cinon	(ca		Weeler
	/Medical Examiner		resulting in death)	Due to (or as a co	nsequence of):	Prosto CARCINE						1/2-1-7
		er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a co	nsequence of):	CAR CENT	3 24/7					1000
	be executed sician and burial-transit	Examiner	that initiated events	C								
,09/	te be executed ysician and e burial-transit	I Ex	resulting in death) Last	Due to (or as a co	nsequence of):							
6876	9 % 9	dical		d				-				
Вох 6	The law requires that the death certification has been signed by the attending phy age 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pr		76				23	3d. Date of deli	very
	death e atte	lcia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live birth 2 ☐ 4 Pregnant at time 9 Unknown		Ectopic pregnancy Other (specify)					Month	Day Year
P.0	at the de	Phys	9 ☐ Unknown  Part II. Other significant conditions co		at societies in the	underhing gauge gu	on in Part I	_	23e Did to	hacco us	e contribute to	the cause of death?
	ires that signed t	by	A Nemia	intributing to death but he	or resulting in the t	andenying cadse give	on in Faiti.		1 U Y	-	<b>K</b> <sub>10</sub> 3 □ Pr	
Records,	w require been si should t	Completed	The Market						24a. Was	an	24b. Were au	topsy findings available
Re	The lav	dwc							autop perfor	med2 200 No	prior to death?	completion of cause of
Vital		Be C	25. Was case referred to medical examiner?				26. Place	of Death	(Check only o	1		
of V	S 2 0	To	1 ☐ Yes 2 No	Hospital: Inpatient	2 ER/Outpatie		4 LI Nui				Other (Spec	cify)
nc	ding After fune	lon:	27. Manner of Death  Natural 5 Pending investigation	28a. Date of Injury (Month, Day Ye	ar) 28b. Time (	Wo	rk? ∣Yes 2 □ N		3d. Describe h	low injury	occurred	
Division	or Attending after death. Director: After in by the fune	fica	3 Suicide 6 Could not be	28e. Place of Injury -	At home, farm, si	treet, factory, office		28	Bf. Location (S City or Tow		Number or Ru	ral Route Number,
á	safter safter al Direc ed in by	Certification:	4 Homicide	building, etc. (S					Ony 07 704	ni, Siale,		
	To the Hoapital or Attent within 24 hours after deall to the Funeral Director. To mpletely filled in by the		(Check only 2 Medicel Exam	sicien: To the best of miner: On the basis of exa	y knowledge, dea mination and/or i	th occurred at the ti	me, date and opinion, deat	d place, ar th occurred	nd due to the d d at the time, d	cause(s) a date and p	and manner as place, and due	stated. to the cause(s)
	To the within 2.	Medical	29b. Signature and title of certifier	and manner stated.		29c. Licens	se number			29d. Date	signed (Monti	n, Day, Year)
	F 3 7 8		VKH15	27/1		Do	0528	365		Apr	al 08	2005
•			30. Name and address of person who	completed cause of death	(Item 23a) (Type							
2	1		K. MICHAEL FILE	MO 1202	QUISIN	BELLEY (	NAY	Box	18, M.	3 0	0720	)
	St. Regist	ate rar	APR 1 2 2005	32. Registrar's	Signature							
Dł	HMH 17 Rev 1/2	ш.	14 11 1 D 2000	Marine &	1				·			

ORIGINAL

			For State	State of Ma		l / Depa	ırtmen	t of H				giene	_	5	14218
			Registrar  1. Decedent's Name (First, Middle, Last	)			imoat	0 0, 2	JOU!!!		2. Date of De				3. Time of Death
	Physicia		Anna Jean Pierce								April	Day 17	, 20	05	8:15 A M
h.	/Medic Examin		4e. Fecility Name (If not institution, give	street and number)			4b. City,	Town, or	Location o	f Death	<u>-</u> -		County of		
			9 Brent Street				Han	cock				Wa	shin	gtor	n
	Funeral Director		036-20-4773	7. Age		st birthday) 81 <sup>Yrs.</sup>	If Under Months	1 Year Days	If Under 2 Hours	Min.	8. Date of Bir (Month, Da June 2:	th ly, Year) 2 <b>,1</b> 92	23	9. Birthp Cour PA	place (State or Foreign ntry)
	and and		Usual Residence of Decedent  10a. State 10b. County		10c. City,	Town or Lo	cation								10d. Inside City Limits
	Mary f she	tor	MD Washingto	าท	Hand	cock									1∯Yes 2□No
	28a	rec	10e. Street and Number		Harr	JOUR .	10f. Zip	Code				10g. Citi	zen of Wh	nat Cou	ntry?
	th with	Funeral Director	9 Brent Street				2	1750				USA			
	deal	ner	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S	i. 13. V	Nas Dece	dent of Hi	spanic Orig	jin? (Spe	cify Yes or No Rican, etc.)	)-		- Americ	can Indian,
36	or it	by Fu	1 Never Married 2 Married	1 ☐ Yes 2 🛣 If Yes, Give	No	Į	1 🗆 Yes		Specify:		,		Specify:		-
Ö	hour tural	q pa	3 \ Widowed 4 □ Divorced  15. Decedent's Edu	Year or Dates:		16a. Deced	tent's Hen	al Occupa	ation		-	16h Ki	nd of Bus		white dustry
5	within 72 hours after death with the Maryland ene. than "returel", or items 23a or 28a-f show than Mudical Examination motified at	Completed	(Specify only highest grad	le completed)		(Give	kind of wo	rk done d se retired	luring most	of working	ıg	100.10	10 01 003	1110337111	loustry
212	d with giene. rr tha	mo.	Elementary/Secondary (0-12)	College (1-4or 5		Admini	istra	tive	Assi	stani	t	Jewe	lrv	Reta	ail Sales
pu	be filed within tal Hygiene. d other than event, the Me	Bec	17. Father's Name (First, Middle, Last)								(First, Middle				
ylaı	should be and Mental markad c	To	Gaylen B. Shaw					Į,			th Spik				
Maryland 21215-0036	s 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mantal Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-1 show other traumatic event. The Medical Event and the modified at		19a. Informant's Name/Relationship (T)								Route Numb				o Code)
	1 and Health em 27 ther t	1 8	Candice Silver/Dau  20a. Method of Disposition	gnter	20b. Pla	3983 ace of Dispo			koad		ordsbur				own, State
Baltimore,	9 = 2 2 = 2	ĺ.,	1 X Burial 2 ☐ Cremation 3 ☐ I		Cer	metery, cren	natory or o	other plac					_	•	om, otato
Ħ	mit. Pa partmen cortant: injury	l i	* 4 ☐ Donation 5 ☐ Other (Specify,	1-0	St.	Peter'			IC U		Aller and		ock,		
Ba	permit. Departmine imports any inju	Ų,	410	5 XU	_										treet 1750-0368
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	lications that caused	the death.	Do not ent	er the mod	le of dyin	g, such as	cardiac o	r respiratory a	rrest,	تاوها	D Z	Approximate Interval Between
	Pnysician		Immediate Cause (Final disease or condition	Myelo											Onset and Death  1 Vear
1	/Medical		resulting in death)	a. Due to (or as			0 0 )		01110						ı year
	Examiner		Sequentially list conditions.	b											
	pe sit	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury	Due to (or as	a conseque	ence of):									
	xecut and il-tran	Examine	that initiated events resulting in death) Last	c Due to (or as	a conseque	ence of):								-	
,092	aath certificate be executed attending physician and for use as the burial-transit	calE		d	·	·									
89	ificate g phy: as the			0.				77							
Вох	h cert endin use	Z/M	230. Was decedent pregnant	23c. If yes, outcome 1 ☐ Live birth			Ectopic p	regnancy					23d. Date		·
	e deat	sicis	in the past 12 months? 1 ☐ Yes 2 ☑No	4☐Pregnant at			Other (s)						Mont	h	Day Year
P.0	The law requires that the death certifical ten has been signed by the attending phoage 2 should be detached for use as the	Physician/Med	9 Unknown			bing in the			an in Dard I		220 Did	loha son u	an contrib	auta to t	he cause of death?
	ires the signer of the d	þ	Part II. Other significant conditions co	intributing to death o	rut not resul	iting in the u	ndenying (	ause givi	en in Part I.			Yes 2			bably 4 Unknown
Ö	w require been sig	etec	<u> </u>								24a. Was				
Vital Records,	ne fav e has ge 2	Completed									auto		pri	or to co	opsy findings available empletion of cause of
ta.		e Cc	25. Was case referred to medical			-			26 Place	of Death	(Check only	2 No	1 [	Yes	2□ No
	Physician: this certific ral director,	OB	examiner?	Hospital: 1 ☐ Inpatie	ent 2 🗆 E	R/Outpatier	nt 3 De	Oth Oth			ne 5 Resi		G □Other	(Specil	(v)
1 of	ng Ph ter th	n: T	27. Manner of Death	28a. Date of Inju	v Year)	28b. Time of	f	28c. Injun Worl	/ at k?	2	8d. Describe	how injur	y occurre	d	,,
sior	Attending it death.	atic	1 Natural 5 Pending 2 Accident investigation				М		Yes 2 □	No					
Divisiori	of or Attending Fafter death.  Director: After din by the funera	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injuding, et			reet, factor	y, office		2	28f. Location ( City or To			r or Rura	al Route Number,
	urs urs	edical Ce	29a. Certifier 1 Certifying Ph	ysician: To the best iner: On the basis o and manner st	f examinati	vledge, deatl	h occurred vestigation	at the tin	ne, date an pinion, deal	d place, a	and due to the ad at the time,	cause(s) date and	and man	ner as s	stated. o the cause(s)
	To the Hosp within 24 ho To the Func completely f	Med	29b. Signature and title of certifier	1			29	c. Licens	e number			29d. Dat	e signed	(Month,	Day, Year)
	0 42 4		Frank R	16	570	mis	5	Duu	1223	7		ПΔ	/20/	200	15
			30. Name and address of person who	completed cause of c							-			200	
	10		Frank B Thomas	III,M.D	. Tu	wo To		way	; Hai	ncoc	k,MD	217	50		
	Sta Regist		31. Date filed (Month, Day, Year)	2005 32. Resistr	ar's Signati	ure	Spark	9							

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 12:39 рм Norman Τ. Queen April 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Prince Georges Hospital Cheverly Prince George's If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign Sept. 20, 192 Washington, D.C. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1<del>√</del>2 M 2 □ F 215-20-3793 77 Yrs Director Usual Residence of Decedent permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinational be reditied at 2028. 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 Yes 2 No Directo Maryland Prince George's Capitol Heights 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20743 United States 514 Shady Glen Dr. 12. Was Decedent Ever in U.S. Amed Forces? 1 E Yes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: Black þ Specify. 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Logistic Supervisor Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Richard Queen Imojene Campbell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12953 Broadview Run Dr. Waldorf, Md. 20602 Paul R. Queen / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 □ Burial 2 □ Cremation 3 □ Removal from State 4/16/2005 ` 4 ☐ Donation 5 ☐ Other (Specify) Resurrection Landover, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Alexander S. Pope Funeral Homes, P.A.
5538 Mariboro Pike/Forestville, Md. 20747 0401083 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ARRHYTHMIA FATAL CARDIAC **Physician** /Medical Due to (or as a consequence of) Examiner DIKIESTIVE HEART Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) been signed by the attending physician and should be detached for use as the burial-transit The law requires that the deeth certificate be executed DISEASE Due to (or as a consequence of): P.O. Box 68760. Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 I Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has 1 Yes 2 No the Hospital or Attending Physician: hin 24 hours after death. the Funeral Director: After this certifice npletely filled in by the funeral director, i 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🗙 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred Certification: Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a 12 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AKRAS HAYES 3001 31. Date filed (Month, Day, Year) 32. Registrar's Signature State APR 1 2 2005 Registrar

		1 - For State Registrar	State of Maryla		artment of F		Mental Hy	giene	5 14220
Physic /Med	lical	Decedent's Name (First, Middle, La:     Richard Scott Ruk     4a. Facility Name (If not institution, give	at		4b. City, Town, o	r Location of Dos	2. Date of De Month	Day	Year 7.3.7M
Exam		5. Social Security Number 6. S	Medical Com	a. last birthday)	If Under 1 Year	bull Sunder 24 Hr		HIC	9. Birthplace (State or Foreign
Funera Directo			<b>™</b> 2□ F 31	Yrs.	Months Days	Hours Mir		ıx, Xearl	New York
ith the Maryland or 28a-f show	ctor	10a. State 10b. County  MD Wicomico		ity, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 🛣 No
with the a or 28	Dire	10e. Street and Number			10f. Zip Code			10g. Citizen of W	/hat Country?
IIIG X IX I 3-0030 be filed within 72 hours after death with the Maryland ttal Hygiene. d other then "neturel; or items 23e or 28e-f show event, the Madiral Examiner must be notified.	by Funeral Director	410 Pine Bluff R  11. Marital Status  1 Never Married 2X Married  3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces?  1		21801 Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 No	lispanic Origin? ( an, Mexican, Pue Specify:	(Specify Yes or No arto Rican, etc.)	USA 14. Race Black Specify.	e American Indian, k, White, etc. White
d ZIZIS-0003 filed within 72 hours Hygiene "neturel", other then "neturel", ant, "the Medical Ex-	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)		life.	dent's Usual Occup kind of work done DO NOT use retired	d) -	orking	16b. Kind of Bu	siness/Industry
ITYICITICI ZIZ Should be filed within nd Mental Hygiene. marked other then imatic event, the Men	To Be Co	17. Father's Name (First, Middle, Last) Garry richard Ruk	1	) DOY L	COUL LIVE	18. Mother's Na	ame (First, Middle ara Crosi	, Maiden Sumam	
Me d 2 d 2 d 2 d 2 d 2 d 2 d 2 d 2 d 2 d	ľ	19a. Informant's Name/Relationship (		1	ng Address (Street				
9 9 = 5		Jody C. Rukat/wi 20a. Method of Disposition 1 Burial 2 Cremation 3	Removal from State	Place of Dispo cemetery, cres	Pine Bluf: position (Name of matory or other place	(e)	Date	20c. Location -	City or Town, State
Dallimo permit Pages Department of Importent: if i any in ury or	3	* 4 □ Donation 5 □ Other (Specification 21. Specification 21. Spe	1	own Cen	-				t Ann, NY al Association
0 85EE	5	23a Party Enter the disease, or com	plications that caused the de	- 5	501 Snow	Hill Rd.	, Salish	ury,MD 2	21804 Approximate
Physician / Medica Examine prusult pru	d,	Sequentially list conditions, if any, leading to immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or in july that initiated events resulting in death) Last	b. Due to (or as a consect.  Due to (or as a consect.  Due to (or as a consect.)	equence of):	Morhegy Uma	to n	yn Mm	mic	Interval Between Onset and Death
cate be executed physician and the burial-transit	cal		a. C My	iil	Entre	whits			
death certiff death certiff e attending	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	23c. If yes, outcome of preg 1 Live birth 2 Fe 4 Pregnant at time of 9 Unknown	tal death 3	□Ectopic pregnancy □ Other (specify)	/		23d. Date Mor	e of delivery oth Day Year
ecords, F.O. law requires that the de as been signed by the 2 should be detached	by	Part II. Dther significant conditions of	contributing to death but not re	esulting in the u	nderlying cause giv	en in Part I.		/	ibute to the cause of death?  3 Probably 4 Unknown
The larate has	Completed						24a. Was auto perfo 1 Ves	psy pormed? d	Vere autopsy findings available rior to completion of cause of eath?
Or VITAL F Physician: Th r this certificate ral director, pag	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 1 Inpatient 2	JED/Outcotion	Oth		eath (Check only		(0
ding h. After	on: T	27. Manner of Death  1. Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	Z8b. Time o Injury	f 28c. Injur Wor	y at k? Yes 2 \( \subseteq No	Home 5 Res	how injury occurre	
DIVISION To the Hospitel or Attending within 24 hours after death. To the Funerel Director: Afte completely filled in by the fune	Certificat	3 Suicide 6 Could not b		home, farm, str cify)	reet, factory, office			Street and Number wn, State)	er or Rural Route Number,
To the Hospitei or within 24 hours afte To the Funerel Dir completely filled in	edical	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exar	nysician: To the best of my kinner: On the basis of examinand manner stated.	nowledge, deat nation and/or in	h occurred at the tir vestigation, in my o	me, date and place pinion, death occ	ce, and due to the curred at the time,	cause(s) and mai date and place, a	nner as stated. and due to the cause(s)
To th To th comp	M	29b. Signature and title of certifier	20 MD		29c. Licens	e number		29d. Date signed	(Month, Day, Year)
10 m		30. Name and a dies of rerson who				+ SAI	ISAur	y mo	
S Regis	State strar	31. Date filed (Month APR Year) 4	7556 1/15 2005 32. Figistrar's Sign	nature //	Somethe)			,	

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

P.O. Box 68760,

Division of Vital Records.

		·	For State Registrar	State of M	Maryland / Depa	artment of F rtificate of		ental Hygier	.000	14222
	Physici	3D	1. Decedent's Name (First, Middle	, Last)	_	- <del></del>		2. Date of Death Month	Day Year	3. Time of Death
	/Medic		ANN L.	ROSENTHAL				PRIL 4, 2	2005	3:58 P M
	Examin	er	4a. Facility Name (If not institution		er)		or Location of Death		tc. County of Death	
	Funeval		SUBURBAN HOSPIT  5. Social Security Number		Age (In yrs. last birthday)	BETHES If Under 1 Year	7	8. Date of Birth	MONTGOMER'	Y place (State or Foreign
	Funeral Director		217-20-7014	1 □ M 2 💢 F	78 Yrs.	Months Days	Hours Min.	(Month, Day, Yea	L926 MARY	ntry)
	pu .		Usual Residence of Decedent							
	show	_	10a. State 10b. County		10c. City, Town or Lo	cation				10d. Inside City Limits 1 X Yes 2 □ No
	urs after death with the Man el', or Itame 23a or 28a-1 sh Examinor must be mutliked	Funeral Director	MARYLAND MONTGO	MERY	ROCKY	/ILLE 10f. Zip Code		100 (	Citizen of What Cou	
	with	ä		TANE ADD	12/					nuy?
	death me 2:	era	5801 NICHOLSON  11. Marital Status	12. Was Decede	nt Ever in U.S. 13.	20852 Was Decedent of F	Hispanic Origin? (Spec	ify Yes or No-	S.A. 14. Race - Ameri	can Indian,
9	or Ita	T.	1 ☐ Never Married 2 💢 Marri	Armed Force	( No		an, Mexican, Puèrto R	lican, etc.)	Black, White,	etc.
933	urel',	d by	3 Widowed 4 Divorced	If Yes, Give Year or Date	s:	1 ☐ Yes 2X No	Ѕрөспу:		Specify: WI	HITE
21215-0036	within 72 hours after death with the Maryland ene. then "neturel", or itame 23a or 28a-1 show the Modical Examinor must be notified at	Completed	15. Decedent (Specify only highes	's Education st grade completed)	(Give	dent's Usual Occup kind of work done	during most of working	g 16b.	Kind of Business/In	ndustry
12	iene. r then	ш	Elementary/Secondary (0-12)	College (1-4d	or 5+) HOMEN	DO NOT use retire	ia)	70	DI HOME	
	filed Hygi Sther	Be Co	17. Father's Name (First, Middle,		HOME	IAKEK	18. Mother's Name		VN HOME en Sumame)	
an	ould be Mental Marked c	To B	NATHAN	LEVI	N		FLORENCE		ROSENS	STOCK
Maryland	P D F F		19a. Informant's Name/Relations!			ng Address (Street	and Number or Rural	Route Number, City		
			HARVEY I. ROSEN	THAL/HUSBA	ND 5801 1	NICHOLSON	I LN., APT.	134, ROC	CKVILLE, N	D 20852
ore	of Healt of Healt if Item 2		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation	3 Demoval from Sta	20b. Place of Dispo cemetery, cre	sition (Name of natory or other pla	Da	ite 20c.	Location - City or T	own, State
Ē	Pages tment of I tent: If Ite		*4 □Donation 5 🛣 Other (S)	pecify)ENTOMBME	NTGARDEN OF	REMEMBRA	ANCE 04/06	/2005 CLA	RKSBURG,	MARYLAND
Baltimore,	permit. Pages Department of Importent: If I any injury or one		21. Signature of Funeral Service	7 / 1	DA	Name and Addre	ess of Facility -GOLDBERG M	EMORTAL C	HAPELS.	INC.
	40260		220 Part Fator the disease of	· Xusti	inseger 1	70 ROCKV	GOLDBÉRG M ILLE PIKE,	ROCKVILI	E, MD 208	
		i l	23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final	only one cause on each	line.	er the mode of dyl	ng, such as cardiac or	respiratory arrest,		Approximate Interval Between Onset and Death
	Priysician /Medical		disease or condition resulting in death)		C OBSTRUCTIV	E PULMON	ARY DISEAS	E	7	YEARS
	Examiner			Due to (61	as a consequence of):					
,000 I		Jer	Sequentially list conditions,	b. Due to (or	as a consequence of:					
<b>S</b>	executed n and ial-transit	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events	c						
700			resulting in death) Last	Due to (or	as a consequence of):					
Q 25	P S S S S S S S S S S S S S S S S S S S	ician/Medicai		d						
3 2×	eath certifica attending pt for use as t	/Me	IF FEMALE:	23c. If yes, outcor	me of pregnancy					
8 <del>-</del> 2	death c e attended for us	ian	23b. Was decedent pregnant in the past 12 months?	1 Live birth	2 Fetal death 3	Ectopic pregnance Other (specify)	Ey .		23d. Date of deliver Month	ery Day Year
× 0.	0 0	hysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknowr		_ Culei (Specily) _				
m So	requires that the	by Pr	Part II. Other significant condition	ons contributing to deat	n but not resulting in the u	nderlying cause gr	ven in Part I.	23e. Did tobacc	o use contribute to t	he cause of death?
rds	w required been sig should b			<del></del>				1 ☐ Yes	2 □ No 3 □ Prol	bably 4XIUnknown
Ann I Record	law requass been 2 should	ompieted						24a. Was an	24b. Were auto	opsy findings available
£ 18	0 4 0							autopsy performed?	? death?	impletion of cause of
Vital	ysicien: Th is certificate director, pag	BeC	25. Was case referred to medical examiner?				26. Place of Death	·		
	ys dir	2	1 ☐ Yes 2 🛣 No	Hospital: 1X Inpa		IL 3LI DOA	Street & Committee of the Committee of t		6 □Other (Specia	fy)
200	ding Ph h. After th funeral	iuoj:	27. Manner of Death 1 X Natural 5 ☐ Pendin		njury 28b. Time o Day Year) Injury	Wo		8d. Describe how in	jury occurred	
senth	ttendi death. ctor: A / the fu	ertification;	2 Accident investig	act he	laium. At hama farm at		Yes 2 □No	Of Logation (Ctroat	and Number or Rura	of Dove Marke
Se	or Attencation death Director:	ertif	4 Homicide determ	building,	Injury - At home, farm, st etc. (Specify)	eer, ractory, office	21	City or Town, Sta		ar noble Number,
Rosentha Division of	ppite ours neral filled	O	29a. Certifier 14 Certifyin	g Physician: To the be	est of my knowledge, deat	h occurred at the ti	ime, date and place, ar	nd due to the cause	(s) and manner as s	stated
ملوا	To the Hos within 24 h To the Fur completely	edicai	(Check only 2 ☐ Medical one)	Examiner: On the basis and manner	s of examination and/or in	vestigation, in my	opinion, death occurre	d at the time, date a	and place, and due t	o the cause(s)
	To the I within 2 To the I complet	Me	29b. Signature and title of certifie	1301		29c. Licens	se number	29d. [	Date signed (Month,	Day, Year)
			Alluel	VIVIN	entas	D225	199	APR	RIL 5, 200	)5
_	10		30. Name and address of person	•		Print)				·
_					30 WISCONSIN		30, CHEVY	CHASE, MI	20815	
	Sta Regist		31 Oate filed (Month, Day, Year) APR 1	2 2005 32.	istrar's Signature	certi				

Registrar

Director

1 and 2 should be tiled within 72 hours atter deeth with the Maryland Heatilb and Mertal Hyglene. I show a 7 is marked other then "natural", or Items 23a or 28a-f show then then "natural", or Items 23a or 28a-f show then traumatic event, Item Medical Examiner must be natilised at permit. Pages 1 and 2: Department of Health ar Important: If item 27 is any injury or other trau

Baltimore, Maryland 21215-0036

P.O. Box 68760,

Division of Vital Records,

**Physician** /Medical **Examiner** 

requires that the death certificate be executed burial-transit and attending physician the for use as the ģ page 2 should be det this certificate funeral director, Atter death. after death the tilled in by To the Hospitel within 24 hours a To the Funerel

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Year Christopher Chapman Richardson, Jr. 9:00 A M 04 05 0.5 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Cumberland Allegany Heart Hospital Sacred If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 5. Social Security Number 7. Age (In yrs. last birthday) (State or Foreign Days Hours Maryland 1 M 2□ F 97 082-07-7066 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 XYes 2 □ No Frostburg Director Maryland Allegany 10g. Citizen of What Country? 10e. Street and Number 100 Village Parkway 10f. Zip Code U.S.A. 21532-Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐Yes 25 No 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates: Yes, Give Specif White 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) telephone company supervisor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Christopher C. Richardson, Sr. Lotta Robinson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2569 Old Frostburg Road Frostburg Maryland 21 19a. Informant's Name/Relationship (Type, Print) 21532 Chapman S. Richardson 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 🗷 Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) 06-Apr-2005 Cumberland Maryland **Cumberland Crematory** 22. Name and Address of Facility
Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 21. Signature of Funeral/Service Licer our pent. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CARDIOGENIC one Da Due to (or as a consequence of) myrcardial Infarction Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? HRONIC DRSTRUCTIVE LUNG 1 Yes 2 No 3 Probably 4 **⊠**Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Inpatient 2 ER/Outpatient 3 DOA Certification; To 28c. Injury at Work? 28a. Dale of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 1 Satural 2 Accident 5 Pending investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) APRIL 5 D2690 97 such 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Cumberland MD  $\mathcal{O}$ ,  $\mathcal{M}$ 925 Bishop Walsh Road Harsit Sidhu 32 Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar APR 0 7 2005

DHMH 17 Rev 1/2001

20

		State of Maryland / Department of Health and Certificate of Death	Reg. No.
-	Physician /Medical	Decedent's Name (First, Middle, Last)  VIOLET MAY REED	2. Dete of Death Month Dey Year April 8 2005 5:55 PM
Ì	Examiner		or Location of Death  4c. County of Death
		Sacred Heart Home HyattsV  5. Social Security Number 6. Sex 7. Age (In yrs. lest birthday) If Under 1 Year   If Under 24 F	
	Funeral Director		Its. 8. Date of Birth (Month, Day, Year)  June 27, 1919  9. Birthplace (State or Foreign Country)  Springton, WV
	deeth with the Meryland ime 23a or 28a-f show funst be notified at neral Director	10a. Stete 10b. County 10c. City, Town or Location	10d. Inside City Limits 1X Yes 2 □ No
	the N	MD Prince George's Hyattsville  10e. Street end Number 10f. Zip Code	10g. Citizen of What Country?
	3a or I	5805 Queens Chapel Road 20782-3898	USA
020	or he market	11. Marital Status  12. Was Decedent Ever in U,S. Armed Forces?  1 Never Married 2 Married  1 Never Married 2 Married  3 Widowed 4 Divorced  1 Ves 2 No Specify:  1 Yes, Give Year or Detes:	
Š	n 72 hours natural', sical En	15. Decedent's Education 16a. Decedent's Usual Occupation	
Baltimore, Maryland 21215-0020	- 1 2 2	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  1 2  16a. Decedent's Usual Occupation (Give kind of work done during most of life. DO NOT use retired)  Home Maker	Own Home
b	be filed to other avent,	17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Last)	lame (First, Middle, Maiden Surname)
/ar	Mente Mente arked artic ev	Crockett Graham Daisy	Violet Wood
a	s ma		Rural Route Number, City or Town, State, Zip Code)
≥,	end eelth n 27 I	Trainey at the expense	Riverdale, Maryland 20737
more	permit. Peges 1 and 2 should be filed within Department of Heelth and Mentel Hygiene. Important: If Itam 27 is marked other than any Injury or other traumetic event, the Mance.  To Be Compi	20a. Method of Disposition  1   ☐ Burial 2 □ Cremation 3 □ Removal from State  4 □ Donation 5 □ Other (Specify)  20b. Place of Disposition (Name of cemetery, crematory or other place)  Fort Lincoln Cemetery	Date 20c. Location - City or Town, State 4/13/05 Brentwood, Maryland
Balti	permit. Depertrainments any inju	21. Signature of Funeral Service Licensee 22. Name and Address of Facility G	asch's Funeral Home, P.A. enue, Hyattsville, Maryland
		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as card	liac or respiratory arrest, Approximate
4	Physician	shock, or heart failure. List only one cause on each line.	Interval Between Onset and Death
a de la companya della companya della companya de la companya della  /Medical	Immediate Cause (Final disease or condition - Congestive Heart Failure	2 Days	
	Examiner	resulting in death)  Due to (or as a consequence of):	2 Days
	P = D	Arrythmia	Years
68760,	ficete be executed  physicien and ss the buriel-transit edical Examiner	Cause (Disease or injury that initiated events	!
Box 68	= D 0	resulting in death) Last	
	the ethe	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23b. Did tobacco use contribute to the cause of death?
P.0	bed by detect	Atherosclerotic Heart Disease	1 ☐ Yee 2X No 3 ☐ Probably 4 ☐ Unknown
Division of Vital Records,	been s should	Coronary Artery Disease	24a. Was an autopsy performed?  24b. Were autopsy findings available prior to completion of cause of death?
8	The lew sete has be page 2 s		1  Yes 2 No 1 Yes 2 No
ita	certificete rector, peg	25. Was case referred to medical 26. Place of 0	Death (Check only one)
<b>&gt;</b>	Physician: 7 rhis cartifice and director, p. To Be C	examiner?	g Home 5 ☐ Residence 6 ☐ Other (Specify)
o uoi	nding Phath.: After the funeral	27. Menner of Deeth  1 X Natural 5 Pending 2 Accident Investigation  28a. Date of Injury (Month, Dey Year)  28b. Time of Injury Injury  28c. Injury at Work?  1 Yes 2 No	28d. Describe how injury occurred
Divis	of Atta	3 Suicide 4 Homicide  6 Could not be determined  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)
	To the Hospital or Attanding Physwithin 24 hours efter deeth.  To the Funeral Director: After this completely filled in by the funeral di Medical Certification: To	29a. Certifier (Check only one)  1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place of examination end/or investigation, in my opinion, death occurred at the time, date and place of examination end/or investigation, in my opinion, death occurred at the time.	
	To the comp	29b. Signeture and fifth of certifier  29c. License number	29d. Date signed (Month, Day, Year)
0	(11)	30. Name end address of person who completed cause of death (Item 23e) (Type, Print)	April 8, 2005
1	(4)	Raman R. Tuli, MD, 3503 Perry Street, Mount Rainier	, Maryland 20712
	State	31. Dete filed (Month, Day, Year)	· · · · · · · · · · · · · · · · · · ·
	Registrar	APR 1 2 2005 Bloom & Spark	

DHMH 16 Rev 6/95

_	Type of I		Didok II	idelible III	A. LIISUI	e All Ook	ICS AIC	ream
	State of	Maryla	nd / Dep	artment of	Health ar	nd Mental	Hygiene	005

			1 - For State Registrar	State of Marylan		rtificate of		Re	g. No.	5 14225
	Physici /Medio			yne Savoy				2. Date of Death Month April 1	0, 2005	
	Examin		4a. Facility Name (If not institution, give Fort Washington Me	dical Center		Fort Wa	or Location of Dea ashingtor	1		George's
	Funeral Director		5. Social Security Number  214-42-7205  Usual Residence of Decedent	7. Age (In yrs. 60	Yrs.	If Under 1 Year Months Days		. (Month, Day,	Year) 1944	9. Birthplace (State or Foreign Country) Maryland
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "neturel", or items 23e or 28e-f show any figury or other treumetic event, if it is Marylad Examinat the mailing at QRCs.	To Be Completed by Funeral Director	MD Charles  10e. Street and Number  7610 Marshall Cor  11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  15. Decedent's Edu (Specify only highest grad  Elementary/Secondary (0-12)  12  17. Father's Name (First, Middle, Last)  William Augustine  19a. Informant's Name/Relationship (7)  Bertha Ann Savoy  20a. Method of Disposition  1 Maurial 2 Cremation 3 F 4 Donation 5 Other (Specify)  21. Signature of Funeral Service Licens	Cner Road  12. Was Decedent Ever in U. Armed Forces?  1	16a. Dece Give life. Own 19b. Mailii 7610 Place of Dispo emetery, cre. Josep	Uses 2 Note that the control of the	Hispanic Origin? (continue)  Specify:  pation ator  18. Mother's Na Mary  t and Number or Facility  check Cem.  esso of Facility uneral Ho	Specify Yes or Norto Rican, etc.)  orking  Imme (First, Middle, M Gertrude  Road, Pom Date 16-2005	Black Specify:  6b. Kind of Bus  Carpen aiden Sumame Swann City or Town, S  Ifret, M  Oc. Location - C	American Indian, white, etc.  American Indian, American Indian In
68/60,	rificate be executed  19 physician and as the burial-fransit  20 physician are the burial-fransit  21 physician are the burial-fransit  22 physician are the burial-fransit  23 physician are the burial-fransit  24 physician are the burial-fransit  25 physician are the burial-fransit  26 physician are the burial-fransit  27 physician are the burial-fransit  28 physician are the burial-fransit  29 physician are the burial-fransit  20 physician are the burial-fransit  20 physician are the burial-fransit  20 physician are the burial-fransit  20 physician are the burial-fransit  20 physician are the burial-fransit  20 physician are the burial-fransit  20 physician are the burial-fransit  20 physician are the burial-fransit  20 physician are the burial-fransit  20 physician are the burial-fransit  20 physician are the burial-fransit  20 physician are the burial-fransit  20 physician are the burial-fransit  20 physician are the burial-fransit  20 physician are the burial-fransit  20 physician are the burial-fransit  20 physician are the burial-fransit  20 physician are the burial-fransit  20 physician are the burial-francit  20 physician are the burial-fransit  20 physician are the bu	ledicai Examiner	23a. Part 1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	ications that caused the deat	uence of):	ter the mode of dy	ing, such as cardia	ac or respiratory arre	2000 <del>4</del>	Approximate Interval Between Onset and Death
P.O. Box	requires that the death certifica een signed by the attending ph hould be detached for use as th	by Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	23c. If yes, outcome of pregna 1 Live birth 2 Feta 4 Pregnant at time of degree Unknown	I death 3[ eath 5[	□Ectopic pregnani □ Other (specify) underlying cause g		23e. Did tob	Mon	of delivery th Day Year bute to the cause of death?
al Records,	The law ate has b page 2 sl	Completed b						24a. Was an autopsy perform	24b. W	dere autopsy findings available for to completion of cause of these 2 No
Division of Vital	or Attending Physicien ifter death. Director: After this certifi in by the funeral director	Certification: To Be	27. Manner of Death  1 Natural 2 Accident 3 Suicide 4 Homicide  29a. Certifier  1 Certifying Phy	28a. Date of Injury (Month, Day Year)  28e. Place of Injury - At h building, etc. (Special sician: To the best of my kno	28b. Time of Injury ome, farm, stry) owledge, deal	of 28c. Injury office the occurred at the	ther: 4 Nursing ury at ork? Yes 2 No	ce, and due to the ca	w injury occurre	in motor vehicles in or Rural Route Number, well Highway
	To the Hospitel within 24 hours a To the Funerel I completely filled	Medical	(Check only one) 2 Medical Exam	iner: On the basis of examina		29c. Licer	opinion, death occurses number		d. Date signed	(Month, Day, Year)

State Registrar 31. Date filed (Month, Day, Year)

APR 1 4 2005

Assignature Assignature Maryland 21201

			for State	State of Maryla	and / Depa		lealth and	•	')	0115	11,225
			Registrar		Cei	rtificate of l	Death	2. Date of I	Reg. No	000	19440
	Physici	an	Decedent's Name (First, Middle, Last,					Month	Da		3. Time of Death
	/Medic		Catherine M. Spin			4b. City, Town, or	A continue of Day	April		2005 County of Deatl	11:00 P <sup>M</sup>
	Examin	er	4a. Facility Name (If not institution, give		•			itri			
			Shady Grove Advent  5. Social Security Number 6. Se		L vrs. last birthday)	Rockvil:	Le If Under 24 Hr	s. 8. Date of 8		Iontgome 9. Birti	
	Funeral Director			M 280F	36 Yrs.	Months Days	Hours Mir	8. Date of E (Month, i 06/17			nplace (State or Foreign untry) trict of Co]
	pu *	1	Usual Residence of Decedent  10a, State 10b, County	10e	City, Town or Lo	ocation					10d. Inside City Limits
	sho	ō	MD Montgomer		ockville						1 ∑Yes 2 □ No
	hours after death with the Maryland tural; or Items 23e or 28e-f show at Examinational be notified at	Director	10e. Street and Number	<i>y</i> 200		10f. Zip Code			10g. Cit	izen of What Co	untry?
	3e or		5204 Norbeck Road			20853			U.	S.A.	
	death ms 2	Funerai	11. Marital Status	12. Was Decedent Ever in Armed Forces?	n U.S. 13.	Was Decedent of H If Yes, specify Cuba	ispanic Origin? (	Specify Yes or I	No-	14. Race - Ame Black, White	
9	or ite	Ē	1 X Never Married 2 ☐ Married	1 ☐ Yes 2 X No If Yes, Give		1 ☐ Yes 2 ☑ No		nto rioan, etc.)		0	
9	urai',	d by	3 Widowed 4 Divorced	Year or Dates:						PT	ack
2	"natu	lete	15. Decedent's Edu (Specify only highest grad		(Give	dent's Usual Occup kind of work done DO NOT use retired	during most of w	orking	16b. K	ind of Business/	Industry
Maryland 21215-0036	withir ane. than	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		ail Sales	,		9	Sales	
0 0	filed Hygi Sther	Be Co	17. Father's Name (First, Middle, Last)				18. Mother's N.	ame (First, Midd	lle, Maider	Sumame)	
<u>a</u>	id be iked ic ev	To B	Donald Allen				Katie	Spinner			
ary	shou ind M mar umat		19a. Informant's Name/Relationship (T)	rpe, Print)	19b. Maili	ng Address (Street	and Number or I	Rural Route Nun	nber, City	or Town, State, 2	Tip Code)
Σ	and 2 laith a i 27 i		Tracy Spinner, Sis				th Ter.#				and 20737
ore	of He of He fiten		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ F	Removal from State		matory or other place		Date		ocation - City or	
Ĕ	G E E E		`4 □ Donation 5 □ Other (Specify,	·F							Maryland
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Deparment of Health and Mental Hygiens. Importantent of Health and Mental Hygiens. Importants if item 27 is marked other than "natural", or items 23e or 28e-f show amy prigny or other treumatic event, the Madical Examinational be notified at once.		21. Signature of Funeral Service Licens	till un	10		ille Pik		ville		and 20852
r			23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	lications that caused the	death. Do not en	ter the mode of dyir	ng, such as cardi	ac or respiratory	arrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	acquired	immu	ne defic	ciency	synd	mon	e	Onset and Death
	/Medical		resulting in death)	Due to (or as a con	sequence of):						
	Examiner		Sequentially list conditions,	b. ————————————————————————————————————							
	ed isit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a con	isequence or):						
	xecut and al-trar	xan	that initiated events resulting in death) Last	C. Due to (or as a con	sequence of):						
760,	ate be executed hysician and he burial-transit	caiE		d							
687	ificate g phy as the			0.				-			
Вох	n cert andin use	N/N	23b. was decedent pregnant	23c. If yes, outcome of pro		□Ectopic pregnancy	,			23d. Date of del	
ω.	that the death certifical ed by the attending phy detached for use as th	Physiclan/Med	in the past 12 months?	4☐ Pregnant at time 9☐ Unknown		Other (specify)	<u></u>		-	Month	Day Year
P.O.	at the by the	Phys	9 ☐ Unknown					02- D	d tab	una nastributa ta	the cause of death?
	The law requires that the death certifical the has been signed by the attending phyage 2 should be detached for use as the	by	Part II. Other significant conditions co	nthouting to death but not	resulting in the t	underlying cause giv	en in Part I.	1 - 1 - 1	□Yes 2	and the second	obably 4 Unknown
Vital Records,	requi	Completed	- parter act 1112					-			
3ec	ne law has b	ldu							as an itopsy orformed2	prior to death?	stopsy findings available completion of cause of
al F								1 ☐ Ye	s 2,000	1 ☐ Yes	210 No
Zi.		o Be	25. Was case referred to medical examiner?  1 Yes 2 No	Hospital: Inpatient	2 □ EB/Outputio	ent 3 DOA Ott	ner.	eath (Check on		6 ☐Other (Spe	cife)
of	Phys or this oral di	<b> -</b>	27. Manner of Death	28a. Date of Injury	28b. Time	of 28c. Injur	ry at	28d. Describ			City)
ion	Attending r death. ector: After by the fune	atio	1 Natural 5 Pending 2 Accident Investigation	(Month, Day Yea	ar) Injury	M 1	Yes 2 □ No				
Division	er des	ertification:	3 Suicide 6 Could not be determined	28e. Place of Injury - building, etc. (St	At home, farm, s	treet, factory, office			n (Street a Town, Stat		ural Route Number,
Ö	itel or rs efte ei Dir led in	O									
	To the Hospital or Attending F within 24 hours effer death. To the Funeral Director: After completely filled in by the funeral	ledicai	29a. Certifier  (Check only one)  Certifying Physical Example (Check only one)	rsician: To the best of my iner: On the basis of examination manner stated.	r knowledge, dea mination and/or i	th occurred at the ti nvestigation, in my o	me, date and pla opinion, death oc	ce, and due to t curred at the tin	he cause(s ne, date an	s) and manner as id place, and due	s stated. to the cause(s)
	To the within To the	Me	29b. Signature and title of certifier			29c. Licens				ate signed (Mont	
	. , , ,		> Alicia J	Mistry	MD	DS	9738		Ap	ril 6,	2003
			30. Name and address of person who			, Print)	، ب	0.6			MD 20850
		ماخ	31. Date filed (Month, Day, Year)				wer	Hive	r-oca	wille,	20030
	St Regist	atė rar	APR 1 2 20	33 Registrar's S	K 60	celes					

Amended Part II, nls, 04/19/05, Allegany Co.

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hydies

or a	1		0	0	
)	and the same	L	2		

			1 - For State Registrar	State	Ji Maiylai		rtificate of		wentai n	Reg. No.	U5	14221
	Physici	an	1. Decedent's Name (First, Mic						2. Date of D Month	eath Day	Year	3. Time of Death
	/Media	al .	Catherin			Smit			April	6 2005		6:13PM M
1	Examir	er	4a. Facility Name (If not institut		umber)			r Location of Deat	th		nty of Death	n
			5. Social Security Number	Hospital	7 Age /In vrs	. last birthday)	Cumber1a		8. Date of B	Alleg		(0)
	Funeral Director		216-22-7354 Usual Residence of Decedent	1□ M 2/2 F		72 Yrs.	Months Days	Hours Min.				hplace (State or Foreign untry) yland
	yland 10w		10a. State 10b. Cour	nty	10c. C	ity, Town or Lo	ocation					10d. Inside City Limits
	Mar Mar	ctor	Maryland Al	legany	Fros	stburg						1 A Yes 2 □ No
	th the	)ire	10e. Street and Number	Honeysuckle I			10f. Zip Code			10g. Citizen o	f What Co	untry?
	23E	rai		407			21532-			USA		
9	u within 72 hours after death with the Maryland jiene. r then "natural", or Itams 23s or 28e-1 show the Medical Examinar must be notified at	Completed by Funeral Director	11. Marital Status  1 Never Married 2 M	12. Was Dec	2 No		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	lispanic Origin? (S an, Mexican, Puer Specify:	Specify Yes or N to Rican, etc.)	o- 14. R	lack, White	rican Indian, a, etc.
Maryland 21215-0036	hours ural',	d b	3 Widowed 4 □ Divorc	ed Year or	Dates:					Spec	White	
15-	n 72 h "nat	lete	15. Deced (Specify only high	lent's Education hest grade completed	)	16a. Dece	dent's Usual Occup kind of work done DO NOT use retired	ation during most of wo	rking	16b. Kind of	Business/l	ndustry
12	within iene. than "	dwo	Elementary/Secondary (0-12	College	(1-4or 5+)			2)		1		
b	Hyg Hyg Than	Be C	17. Father's Name (First, Middle	le, Last)		secreta	ry	18. Mother's Nar	me (First, Middle	unknow a, Maiden Suma		
lan	2 to 2 to 2	ToB	Edwin & Coins					D ' D				
ary	R D E H	-	19a. Informant's Name/Relatio	nship (Type, Print)		19b. Mailir	ng Address (Street	Bessie Ba and Number or Ri	<b>nctinc</b> ural Route Numi	ber, City or Tow	n, State, Z	ip Code)
	and 2 lealth a m 27 is		Shirley Brady	dau	ehter	206 Br	addock High	ts From	sthuro	Mars	land	21532
ore	iges 1 nt of He If itan or oth		20a. Method of Disposition  1 Burial 2 Cremation		20b.	Place of Dispo cemetery, crer	sition (Name of natory or other place	28)	Date	20c. Location		
Baltimore,	Pa ant ury		'4 □Donation 5 □ Other			mberland	Crematory	07-	Арг-2005	Cumberlar	nd N	laryland
Salt	permit. Pag Department Important: eny injury c		21. Signature of Funeral Service	ce Licensee	/	22	. Name and Addres	ss of Facility				
_	₫Ω <u>5</u> 6 8		John	KKU	rit	Du	rst Funeral	Home, 57]	Frost Ave.	, Frostbu	rg MI	21532
П			23a. Part1 Enter the disease, shock, or heart failure. L	or complications that ist only one cause on	caused the dea each line.	th. Do not ent	er the mode of dyin	ig, such as cardia	c or respiratory	arrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	a PULM	ONARY E	MBOLISN	1					Onset and Death IMMEDIATE
	/Medical Examiner		resulting in death)	Due to	(or as a consec	quence of):						
		-	Sequentially list conditions,	b. Due to	(or as a consec	THEREO OF						
	ted	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	₹ 500 10	(or as a consec	querice orj.						
	al-tra	Examiner	that initiated events resulting in death) Last	c	(or as a consec	quence of):						
68760,	rtificate be executed ng physician and as the burial-transit										)	
89	ifficate g phy as the	Medical							0	Eng or	(a)	4 PR. 1 6, 2001
.O. Box	ath cer attendir for use	Physician/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 27 No 9 □ Unknown	1 Live	itcome of pregn birth 2 Feta nant at time of c nown	aldeath 3	Ectopic pregnancy Other (specify)	,			ate of deliv Ionth	very Day Year
<u>α</u>	res that the de signed by the a be detached		Part II. Other significant condi	itions contributing to d	death but not res	sulting in the u	nderlying cause give	en in Part I.	23e. Did	tobacco use cor	ntribute to	the cause of death?
Vital Records,	es igr	d by	Fall at home									bably 4 Unknown
00	≥ ±1 0	Completed							24a. Was	an 24h	Were aut	opsy findings available
Re	9 ~ e	mo							auto	psy ormed?	prior to co death?	ompletion of cause of
ta	sician: Th certificate rector, pag	O	25. Was case referred to medic	cal				26. Place of Dea	1 Yes	20 No	1 Yes	2 No
	Physician: this certific ral director,	0 8	examiner? √∠Yes 2 No	Hospital:	Inpatient 2	ER/Outpatien	t 3 DOA Othe	or	lome 5 Res		her (Speci	ify)
JO L	ng Ph ter th	Ju: T	27. Manner of Death 1 □ Natural 5 □ Pend	28a. Date		28b. Time of		the second secon	28d. Describe	how injury occu	ırred	
<u>Sio</u>	Attending r death. actor: After	atlc	Accident inves	stigation	T. 32005	2:00A1		Yes 2 XNo	patien	t fell :	in ba	throom
Division	or Attendater deat Diractor: in by the	Certification;	3 Suicide 6 Coul 4 Homicide dete	mined 286. Place	e of Injury - At h ling, etc. (Specia	ome, farm, str	eet, factory, office		28f. Location ( City or To	Street and Num wn, State)	ber or Run	al Route Number,
	ital curs af				sist. 1							n F'burg
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	edical	29a. Certifier (Check only one)  1 Certify 2 Medica	ying Physician: To the all Examiner: On the band man	e best of my kno pasis of examina nner stated.	owledge, death ation and/or inv	occurred at the time restigation, in my or	ne, date and place pinion, death occu	, and due to the rred at the time,	cause(s) and m date and place	tanner as s , and due t	itated. o the cause(s)
	To the within 2. To the complete	Σ	29b. Signature and title of certif	fier 0 A			29c. License	number		29d. Date sign	ed (Month,	Day, Year)
	/		Save ( L	SH M	<b>.</b>		DO	0018216		APRIL	7, 20	005
	7. T.		30. Name and address of person				*					
	7/2		SMITH, STEVEN	R., M.D.,	600 MEN	MORIAL	AVENUE, (	CUMBERLAN	ND, MD 2	21502		
	Sta Registr		31. Date filed (Month, Day, Yea	8 2005	Registrar's Signa	auge Ag	ods)					

hysici	an	Decedent's Name (First, Middle,								<ol><li>Date of I Month</li></ol>	Death Da	ıy	Year	3. Time of	Death
/Medi			ne Savage							Apri]	L 9,	2005		3:08	A
Examir	ner	4a. Facility Name (If not institution, Southern Maryla	-					Location of	of Death			. County o			
				7. Age (In yrs. la	ast hirthday)		Linto	Of 1	24 Hrs.	8. Date of B				eorge (State o	or Form
uneral rector		577-44-9240	1 □ M 2 □XF	76	Yrs.		Days	Hours	Min.	Feb.	Day, Year,	929	Cour	place (State on try)  Carol:	ina
		Usual Residence of Decedent									<u> </u>	223		Caron.	TITE
Show	_	10a. State 10b. County			, Town or Lo								1	10d. Inside Ci	-
189-1	Director		e George	C	linto				-		1			1 X Yes	
ben ben	Di	10e. Street and Number 5923 Surrattsv	rillare De			10f. Zip (		_			10g. Ci	tizen of W	hat Cour	ntry?	
or Iteme 23e or 28e-f show reinst rest be notified at	Funerai	11. Marital Status		IVE dent Ever in U.S	S. 13.		2073.		nin? (Spe	cify Yes or I	No-	USA 14. Race	- Americ	can Indian,	
or Iten	Ξ	1 Never Married 2 Marrie	Armed For ed 1 ☐ Yes	ces? 2X∑No		Was Decede			, Puerto	Rican, etc.)			, White,	etc.	
e, ja	b	3℃ Widowed 4 Divorced	If Yes, Give Year or Da	e ites:	-	1 ☐ Yes 2	2 PNo	Specify:				Specify:	В.	lack	
n "natural", o fedical Exam	Completed	15. Decedent's (Specify only highest	's Education t grade completed)		(Give	dent's Usual	k done d	lurina mosi	t of worki	ng	16b. K	(ind of Bus	siness/In	dustry	
r than	mpi	Elementary/Secondary (0-12)	College (1-	-4or 5+)		DO NOT use	e retired)	)			По	J	т	. 7	
_ =		7th 17. Father's Name (First, Middle, L	ast)		Pre	esser		18 Mothe	r's Nama	(First, Midd		lman		nary	_
D 6	o Be	Thomas Robinso							y Da		io, maidei	r oumanne	9/		
7 is marked treumatic ev	ř	19a. Informant's Name/Relationsh			19b. Maili	ng Address	(Street a				ber. City	or Town, S	State. Zip	Code)	
Te I		Cynthia Savage	/Daughter			3 Surr					-				
		20a. Method of Disposition			ace of Dispo	osition (Nam matory or oti	ne of		ו	ate		ocation - (			
int: If		1 ☑ Burial 2 ☐ Cremation `4 ☐ Donation 5 ☐ Other (Sp		state !	-	on Cem		1	4/21	/05	Arl:	ingto	n V	77 <u>\</u>	
Importent: If any injury or once.		21. Signalure of Funeral Service L	icensee		22	2. Name and	d Addres							rvices	3
트등점		CONIN.	Slike	ul	6	5500 A	11er	ntown	P.d	Camo	Chris	~~~	MD 2	0740	
sician edical miner		23AParti Enter the disease, or c shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)	a	ach line.				g, such as	cardiac o		arrest,		PID 2	Approximate Interval Bety Onset and D	weer
edical miner	i Examiner	shock, or heart failure. List of Immediate Cause (Final disease or condition	a	ach line.	Do not entire of):			g, such as	cardiac o	r respiratory	arrest,		FID 2	Approximate Interval Bety	weer
ding physician and se as the burial-transit		shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events	a. Due to (a) b. Due to (a) c. Due to (a) d. 23c. If yes, outc.	or as a consequence of pregnar	ence of):	ter the mode	e of dying	g, such as	cardiac o	r respiratory	sthma		o of delive	Approximate Interval Betwoen and D	weer
attending physician and directions as the burial-transit		shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant	a. Due to (a) b. Due to (a) c. Due to (a) d. 23c. If yes, outc.	or as a consequence of pregnar the 2 Fetal and at time of de	ence of):	ter the mode	e of dying	g, such as	cardiac o	r respiratory	sthma	23d. Date	o of delive	Approximate Interval Betwoen and D	ween Death
gned by the attending physician and per detached for use as the burial-transit be detached for use as the burial-transit	by Physician/Medical	shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1  yes 2 No	a	or as a consequence of pregnant at time of deliver	Do not entire of):  Hence of):  Hence of):  Hence of):  Hence of):	Ectopic pre	e of dying	g, such as	cardiac o	respiratory	sthma	23d. Date Mon	e of delive	Approximate Interval Betwoen and Done and Done and Done and Done and Done and Done are approximately	ween Death
us been signed by the attending physician and use as the burial-transit as the burial-tr	by Physician/Medical	shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 Unknown	a	or as a consequence of pregnant at time of deliver	Do not entire of):  Hence of):  Hence of):  Hence of):  Hence of):	Ectopic pre	e of dying	g, such as	cardiac o	23e. Did	sthma	23d. Date Mon	e of delive th bute to th	Approximate Interval Betwoen and Done and Done and Done and Done and Done and Done are cause of done cause of done and Done and Done are cause of done and Done are cause of done and Done are cause of done and Done are cause of d	eath Jukno
te has been signed by the attending physician and up of age 2 should be detached for use as the burial-transit up of up	Completed by Physician/Medical	shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate for the sequence of injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1  yes 2  No 9  Unknown  Part II. Other significant condition	a	or as a consequence of pregnant at time of deliver	Do not entire of):  Hence of):  Hence of):  Hence of):  Hence of):	Ectopic pre	e of dying	Br Br in Part I.	cardiac o	23e. Dir 24a. Wi au pe	d tobacco Yes 2 as an lopsy of cornect?	23d. Date Mon	o of deliver th	Approximate Interval Betwoen and Donset and	eath Jukno
certificate has been signed by the attending physician and U P rector, page 2 should be detached for use as the burial-transit	o Be Completed by Physician/Medical	shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 Unknown	a. Due to (c b. Due to (c c. Due to (c d. 23c. If yes, outc 1 Live bi 4 Pregna 9 Unkno	or as a consequence of pregnanth 2 Fetal and at time of december of the consequence of th	Do not entered of):  Hence of)	Ectopic pre	egnancy egrancy early	Br Br an in Part I.	conch	23e. Die 1 24a. We au pe 1   Yes	d tobacco Yes 2 as an topsy formed? 2 No	23d. Date Monuse contril	o of delive th  bute to th  3 □ Prob  lere autorior to coreath? □ Yes	Approximate Interval Betwoen and Development a	eath dear
If the certificate has been signed by the attending physician and uneral director, page 2 should be detached for use as the burial-transit of the body of the burial-transit of the body of the burial-transit of the body of the burial-transit of the body of the burial-transit of the buri	To Be Completed by Physician/Medical	shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate failure in the cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1	Due to (c b. Due to (c c. Due to (c d. Due to (c d. Pregna g Unkno ns contributing to de hospital: Ir 28a. Date of (Month	or as a consequence of pregnar the 2 Fetal and at time of december 2 fetal and at the but not result the patient 2 Fetal and at the but not result the patient 2 Fetal and at the but not result the patient 2 Fetal and at the but not result the patient 2 Fetal and at the but not result the patient 2 Fetal and at the but not result the patient 2 Fetal and a patient 2 Fetal a	Do not entire of):  Hence of):  Hence of):  Hence of):  Hence of):	□Ectopic pre □ Other (spe	egnancy egnancy ause give	Br Br In Part I.	conch	23e. Dir 24a. Wi au pe	d tobacco Yes 2 as an topsy rformed? 2 No	23d. Date Monuse contril	o of deliver the bute to the same of deliver to the same of the sa	Approximate Interval Betwoen and Development a	eath Jukno
tor: After this certificate has been signed by the attending physician and up the funeral director, page 2 should be detached for use as the burial-transit of the funeral director.	o Be Completed by Physician/Medical	shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate the state of the	Due to (c b. Due to (c c. Due to (c d. 23c. If yes, outc 1 Live bi 4 Pregna 9 Unkno ns contributing to de (Montr ation oot be 28e. Place	or as a consequence of as a consequence of pregnar the 2 Fetal and at time of delivers. The consequence of t	Do not entered of):  Hence of)	Ectopic pre Other (spe	egnancy ecify)  ause give	Br Br Br Br Br Br Br Br Br Br Br Br Br B	of Death	23e. Die 24a. Wie au pe 1 Yes (Check online 5 Re 28d. Describ	d tobacco Yes 2 as an topsy formed? 2 No	23d. Date Mon use contril No 24b. W prode 110 6 Other ry occurre	e of deliver th  bute to th  Jere autorior to coreath?  Yes	Approximate Interval Betwoen and Development a	eath eath
-unerel Director: After this certificate has been signed by the attending physician and by filled in by the funeral director, page 2 should be detached for use as the burial-transit by the funeral director.	Certification; To Be Completed by Physician/Medical	shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate and the sequence of injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (c b. Due to (c c. Due to (c d. 23c. If yes, outc 1 Live bi 4 Pregna 9 Unkno ns contributing to de (Montr ation oot be 28e. Place	or as a consequence of as a consequence of pregnar the 2 Fetal and at time of deliven.  Appatient 2 Effinjury At horing, etc. (Specify)  best of my know is is of examinati	nence of):  Hence	Ectopic pre Other (spe	egnancy ecify)	Br Br Br Br Br Br Br Br Br Br Br Br Br B	conch	23e. Dir 24a. Wing 24a. Wing 1 Yes (Check only me 5 Re 28d. Describ	d tobacco Yes 2 as an lopsy formed? 2 No vone sidence e how inju	23d. Date Mon  use contril  No  24b. W pr  de 11  6  Otherry occurrer  and Number  a) and man	of deliver th  bute to th  Prob  Vere autorior to coreath?  Yes  r (Specify ad	Approximate Interval Betwoen and I onset a	reath reath
Director: After this certificate has been signed by the attending physician and bright by the funeral director, page 2 should be detached for use as the burial-transit bright br	To Be Completed by Physician/Medical	shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate fails and the cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown  Part II. Other significant condition  25. Was case referred to medical examiner? 1   Yes 3   No  27. Manner of Death 1   Anatural   5   Pending investig: 3   Suicide   6   Could not determine (Check only 2   Medical E	a. Due to (c b. Due to (c c. Due to (c d. Du	or as a consequence of as a consequence of pregnar the 2 Fetal and at time of deliven.  Appatient 2 Effinjury At horing, etc. (Specify)  best of my know is is of examinati	nence of):  Hence	Ectopic pre Other (spe Inderlying ca	egnancy ecify)	g, such as Br  26. Place 37. 4 Nu 47. Yes 2 1	conch	23e. Dir 24a. Wing 24a. Wing 1 Yes (Check only me 5 Re 28d. Describ	d tobacco Yes 2 as an topsy formed? 2 No yone) sidence e how inju (Street ar own, State	23d. Date Mon use contril No 24b. W pr de p 1 1 6 Other ry occurre nd Numbe ) and man d place, an	e of delive th  bute to th  3 Prob  fere autorior to coreath?  Yes  r (Specify  d  ar or Rura	Approximate Interval Betwoen and I onset a	eath'  /ear  eath'  Jinkno availatase
-unerel Director: After this certificate has been signed by the attending physician and by filled in by the funeral director, page 2 should be detached for use as the burial-transit by the funeral director.	edical Certification; To Be Completed by Physician/Medical	shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate state of the conditions of any, leading to immediate state of the conditions of any, leading to immediate state of the conditions of any leading in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown  Part II. Other significant condition  25. Was case referred to medical examiner? 1   Yes 3   No  27. Manner of Death 1   Natural   5   Pending investig: 3   Suicide   6   Could not determine the condition of the	a. Due to (c b. Due to (c c. Due to (c d. Du	or as a consequence of as a consequence of pregnar the 2 Fetal and at time of deliven.  Appatient 2 Effinjury At horing, etc. (Specify)  best of my know is is of examinati	nence of):  Hence	Ectopic pre Other (spe Inderlying ca	egnancy egrify)  ause give  A Othe Bc. Injury Work 1 1 Y	g, such as Br  26. Place 37. 4 Nu 47. Yes 2 1	conch	23e. Dir 24a. Wing 24a. Wing 1 Yes (Check only me 5 Re 28d. Describ	d tobacco Yes 2 as an topsy formed? 2 No yone) sidence e how inju (Street ar own, State	23d. Date Mon use contril No 24b. W pr de p 1 1 6 Other ry occurre nd Numbe ) and man d place, an	e of delive th  bute to th  3 Prob  fere autorior to coreath?  Yes  r (Specify  d  ar or Rura	Approximate Interval Betwoen and Done cause of diably 4 Dupsy findings ampletion of cause (s)	eath'  /ear  eath'  Jinkno availatase
-unerel Director: After this certificate has been signed by the attending physician and by filled in by the funeral director, page 2 should be detached for use as the burial-transit by the funeral director.	edical Certification; To Be Completed by Physician/Medical	shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate state of the conditions of any, leading to immediate state of the conditions of any, leading to immediate state of the conditions of any leading in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown  Part II. Other significant condition  25. Was case referred to medical examiner? 1   Yes 3   No  27. Manner of Death 1   Natural   5   Pending investig: 3   Suicide   6   Could not determine the condition of the	Due to (a b. Due to (a b. Due to (a c. Due to (a d. Due t	or as a consequence of pregnar rth 2 Fetal and at time of dewn at the but not result finjury h. Day Year)  of Injury - At horing, etc. (Specify, best of my know is sis of examination er stated.	Do not entire and a service of the s	Ectopic pre Other (spe Inderlying ca Inderly	egnancy egrify)  ause give  A Othe Bc. Injury Work 1 1 Y	g, such as Br  26. Place 37. 4 Nu 47. Yes 2 1	conch	23e. Dir 24a. Wing 24a. Wing 1 Yes (Check only me 5 Re 28d. Describ	d tobacco Yes 2 as an topsy formed? 2 No yone) sidence e how inju (Street ar own, State	23d. Date Mon use contril No 24b. W pr de p 1 1 6 Other ry occurre nd Numbe ) and man d place, an	e of delive th  bute to th  3 Prob  fere autorior to coreath?  Yes  r (Specify  d  ar or Rura	Approximate Interval Betwoen and Done cause of diably 4 Dupsy findings ampletion of cause (s)	eath  linkn avail ause

			1 - For St	ate of Maryland / D	Department of F		ntal Hygien	.000	14229
	Physici /Medic		1. Decedent's Name (First, Middle, Last)	yard Tho	mas S	r.  2	. Date of Death	ay Year	3. Time of Death 7:08 A M
	Examin		4a. Facility Name (If not institution, give stree  Southern Marzyla  5. Social Security Number 6. Sex		Clinto	r Location of Death			20 rge 5 lace (Gate or Foreign
	Funeral Director		579-46-281Z 1MM Usual Residence of Decedent	20F 70	Yrs. Months Days	Hours Min.	(Month, Day, Yea	1435 Marz	try
	e Marylan Ba-f show	ctor	Maryland Prince Gerr	10c. City, Town	or Location			10	0d. Inside City Limits 1
	h with th	al Directo	18045 Horsehead	Riad	10f. Zip Code	13	10g. C	itizen of What Coun	try?
336	be filed within 72 hours after death with the Maryland nat Hyglene. Id other than "natural", or Itema 23e or 28e-f show event, Ite Medical Exertil at mark to Indiffication.	by Funeral	11. Marital Status 12. V	Vas Decedent Ever in U.S. Imed Forces?  ☐ Yes 2 ☑ No Yes, Give ear or Dates:	13. Was Decedent of H If Yes, specify Cuba 1 Yes 2 No	lispanic Origin? (Speci an, Mexican, Puerto Ri	fy Yes or No- can, etc.)	14. Race - America Black, White, e Specify:	
15-0036	n 72 hou "natura	Completed	15. Decedent's Education (Specify only highest grade con		Decedent's Usual Occup (Give kind of work done of life. DO NOT use retired	pation during most of working	16b.	Kind of Business/Inc	lustry
2121	filed within Hygiene. Ither than "	Comp	12_	college (1-4or 5+)	Plumbe		14	.C. La	dd
Maryland	Mer Mer	To Be	17. Father's Name (First, Middle, Last)  Robert Lee 1  19a. Informant's Name/Relationship (Type, F	namas	Mailin Add (Cara	18. Mother's Name (		Ede	len
-	nd 2 state are although are 27 ls		Helen E. Thomas /	Wife 18	Mailing Address (Street	read Rd,	Brandy	in Mi	20613
Baltimore	00		20a. Method of Disposition  1 Burial 2 Cremation 3 Remo  4 Donation 5 Other (Specify)	comptan	Disposition (Name of y, crematory or other place	Dat 4-16		Location - City of Tor	wn, State
Balti	permit. Pag Department Importent; I any Injury o		21. Signature of Fuhrral Service Licensee	eter 191	22. Name and Address Aclams Fun		PA A	suasca V	4D
	Pnysician		23a. Part1. Enter the disease, or complication shock, or heart failure. List only one call immediate Cause (Final disease or condition	ns that cau ed the death. Do ruse on page line.	not enter the mode of dyin	ng, such as cardiac or r	espiratory arrest,		App ximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as I consequence of	Paral D	ile on	House	ah La	Thouls.
	outed id ransit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequence of	Censon	2. Come en	tu The	n lakel	1 North-
8760,	sate be executed physiclen and the burial-transit	cal	resulting in death) Last	Due to (or as a consequence of	elevan	2 Con	nen	e I	monly
.O. Box 6	The law requires that the death certificate be executed to has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	Physician/Med	in the past 12 months?	yes, outcome of pregnancy □Live birth 2 □ Fetal death □ Pregnant at time of death □ Unknown	3 □Ectopic pregnancy 5 □ Other (specify) _	,		23d. Date of deliver Month	ry Day Year
<u>α</u>	w requires that been signed b should be deta	by	Part II. Other significant conditions contribu	ting to death but not resulting in	the underlying cause give	en in Part I.		use contribute to the	e cause of death?
Records,		Completed					24a. Was an autopsy performed?	prior to com death?	osy findings available apletion of cause of
f Vital	ysiclen: ils certific director,	To Be	25. Was case referred to medical examiner?  1 \( \subseteq \text{Yes} \) 2 \( \subseteq \text{No} \)  Hospi	tal: 1  Inpatient 2  ER/Ou	tpatient 3 DOA	26. Place of Death (		6 ☐Other (Specify	)
ion of	Hospital or Attending Physiclen: 4 hours after death. Funeral Director: After this certificately filled in by the funeral director.		2 ☐ Accident investigation	la. Date of Injury 28b. T	ime of 28c. Injury World	y at 286 k? Yes 2 □ No	d. Describe how inj		
Division	s after de	Certification;	3 Suicide 6 Could not be determined	e. Place of Injury - At home, fai building, etc. (Specify)	rm, street, factory, office	286	Location (Street a City or Town, Sta	und Number or Rural te)	Route Number,
	To the Hospital or within 24 hours after To the Funeral Director Completely filled in the Funeral or the Funeral Director Completely filled in the Funeral D	edlcal (	(Check only 2 Medical Examiner:	n: To the best of my knowledge On the basis of examination and and manner stated.	d/or investigation, in my o	pinion, death occurred	at the time, date ar	nd place, and due to	ited. the cause(s)
	To the within 2 To the comple	Me	29b. Signature and title of certifier		29c. License	e number	29d. D	ate signed (Month, E	lay, Year)
C	0 5		30. Name and a ress person who comple	ited cause of death (Item 23a) (	Type, Print)	(1)	01	111,09	<b>,</b>
1	\$\frac{5}{5}\$		1)r, 1Serua Laxmi 31. Date filed (Month, Day, Year) APR 1 4 2005	nd manner stated.  Ited cause of death (Item 23a) (  7700 Uld 13  32. Fegistrar's Signature	Such the	Suite 101,	Clinton	m1)	20735
	Registr	ar	APK 1 4 2003	A MANUEL ST	Marie				

			State of Maryland / Department of Health and M  State Certificate of Death		giene	5 14230
	Physici	200	Decedent's Name (First, Middle, Last)	2. Date of De	ath Dav-	3. Time of Death
	/Media	al	Walter Sorber Thompson, III	APRIL	15	2008 1430 M
	Examin	er :	4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death  Upper Chesapeake Medical Center  Bel Air			nty of Death Harford
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birt (Month, Da 8/5/35	th v. Year)	Birthplace (State or Foreign Country)
0	Director		166-28-8810 69 Yrs.	8/5/35	<b>,</b> , , , , , , , , , , , , , , , , , ,	Pennsylvania
3	Mo Mo		Usual Residence of Decedent           10a. State         10b. County         10c. City, Town or Location		.*	10d. Inside City Limits
_	Marylen s-f show filed at	tor	MD Harford Aberdeen			1 ☐ Yes 2 🔀 No
1	th the or 28s	Director	10e. Street and Number 10f. Zip Code		10g. Citizen o	f What Country?
5	ath wi	ral	1106 Montreal Drive 21001		U.S.F	
1	efter dea or Items coliner on	Funeral	11. Marital Status  12. Was Decedent Ever in U.S. Amed Forces?  1 □ Never Married 2 □ Married 12 Never Married 2 □ No	ecify Yes or No Rican, etc.)	- 14. Ra	ace - American Indian, lack, White, etc.
4-15	72 hours efter death with the Marylend Instural', or Items 23e or 28e-f show ofcet Examinational be notified at	by	3 ☐ Widowed 4 ☐ Divorced Year or Dates:		Spec	white
7-20-9	72 hour natural	Completed	15. Decedent's Education  (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done during most of work.)	ina		Business/Industry
ر 2121	S c 3	mple	Elementary/Secondary (0-12) College (1-4or 5+) life. DO NOT use retired)	,,,,g	Gii 1	Conning
- 73	D 0 5		12 5 Mechanical Engineer  17. Father's Name (First, Middle, Last) 18. Mother's Name	e (First Middle		Service
0384 Maryland	2 should be filed with and Mental Hygiene is marked other tha eumatic event, the	To Be		ise Br		
33 ary	12 should th and Mer 7 is marke treumatic		19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rura	al Route Numbe	er, City or Tow	n, State, Zip Code)
36	5 # Z E			oerdeen		
	8		1 ☐ Burial 2 ☑ Cremation 3 ☑ Removal from State	Date		n - City or Town, State
N 8003 Baltimore,	permit. Page Department of Importent: If any Injury or		^ 4 □ Donation 5 □ Other (Specify) R. A. Ferris & Co. 4/19 21. Signature of Funeral Service Licensee 22. Name and Address of Facility	9/05	West (	Chester, PA
M80030384 Baltimore, Maryland	perm Depa Impo any I		KINSTER A UNGLESSEE Tarring-Cargo Funes Aberdeen, Maryland	ral Home 21001	e, P.A.	
#			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac of shock, or heart failure. List only one cause on each line.			Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition  Multiple Myeloma			Onset and Death 18 Worths
	/Medical Examiner		Due to (or as a consequence of):			
NO		er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury			
	cuted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events			
( 0	ate be executed hysicien and the burial-transit		resulting in death) Last Due to (or as a consequence of):			
\$760	ate the	Physician/Medical	d			
* ×	eath certific attending pl for use as t	/Me	IF FEMALE: 23c. If yes, outcome of pregnancy		224 5	Date of delivery
3 8	atter	clan	23b. Was decedent pregnant in the past 12 months?  1   Yes   2   No   1   Yes   2   No   2   Yes   1   Yes   2   Yes			Date of delivery Month Day Year
> 0	at the de by the	hysi	9 ☐ Unknown 9 ☐ Unknown			
S	as the	by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.			ntribute to the cause of death?
Sord	w require been si should t	eted	T CONTROL TOTAL	101	res 2. PNo	3 ☐ Probably 4 ☐Unknown
50 3ec	e law has b	ompleted		24a. Was autop	an 24b ssy rmed?	Were autopsy findings available prior to completion of cause of death?
a	Th ete pag	e Co	GE Was and referred to modified	1 Yes	2 🗆 No	1 Yes 2 No
\$ \$	Ser	To Be	25. Was case referred to medical examiner?  1 Yes 2 No Dither: 4 Nursing Ho			ther (Snecifu)
0.6	ding Phys h. After this funeral di		27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at	28d. Describe h		
1-C !!	endin sath. or: Aft he fur	atio	2 ☐ Accident investigation M 1 ☐ Yes 2 ☐ No			
Divisi	or Att	ertification;	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (5 City or Tox		nber or Rural Route Number,
	To the Hospitel or Attending Pr within 24 hours after death. To the Funerel Director: After the completely filled in by the funera	O	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place,	and due to the	cause(s) and n	nanner as stated.
	he Ho in 24 t he Fu pletely	edical	(Check only) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurr and manner stated.	ed at the time,	date and place	, and due to the cause(s)
	To t To t	Σ	29b. Signature and title of certifier  29c. License number			ned (Month, Day, Year)
	2				of one	16,2005
	0		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  MYO MIN (Ph.D.) 602 South Atwood Road #200,  31. Date filed (Month, Day, Year)  APR 1 8 2005 Separature	BelA	ir, N	D21014
	Sta		31. Date filed (Month, Day, Year) 32. Registra's Signature			•
	Regist	al :	MIN TO TOO & LANGE TO TAKE			

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** Year Lillian Elizabeth March 31, 2005 8:15 P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 616 Braddock Avenue LaVale Allegany If Under 1 Year | If Under 24 Hrs. | 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 ☐ M 2 🖫 F 88 Yrs. Director 12/05/1916 217-30-1587 Maryland Usual Residence of Decedent with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 27 is marked other than "natural; or items 23a or 28a-f show traumatic event, the Medical Examinar must be notified at MD Director Allegany LaVale 1 ☐ Yes 2 ☑ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 616 Braddock Avenue 21502 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. s 1 and 2 should be filed within 72 hours after of Health and Mental Hygiene. Item 27 is marked other than "natural", or Itei 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify. 3 ₩idowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) 11 Food Service Public Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Jacob Crosby Alice McMullen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Betty Cover / daughter P.O. Box 3313, LaVale, Maryland 21504 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of Hi
important: If iter
any injury or oth 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State \* 4 Donation 5 Other (Specify) 04/04/2005 Restlawn Mem. Gardens LaVale, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Adams Family Funeral Home, P.A. 404 Decatur Street, Cumberland, Maryland 21502 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Acute Myocardial Infarction one hour /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examine requires that the death certificate be executed burial-transit that initiated events attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical 4,200 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Dav Year 4☐Pregnant at time of death 5 Other (specify) been signed by the s should be detached i 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Diabetes 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autonsv performed? certificate 1 Yes 2 🗓 No 2 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Released Be 26. Place of Death (Check only one) Released 1 ∑ Yes Hospital: Other: 4 Nursing Home 5 AResidence 6 Other (Specify) 2 1 Inpatient 2 ER/Outpatient 3 DOA this After thi funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Certification; 28d. Describe how injury occurred 1 Natural 5 Pendina death. 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: filled in by the 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after of To the Funeral Direct completely filled in by 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of conflict 29c. License number 29d. Date signed (Month, Day, Year) April 4, 2005 D 33417 4 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) James R. Moen, M.D., 1068 National Highway, LaVale, Maryland 31 Date filed (Month, Day, Year) 3. Registrar's Signature State APR 0 1 2005 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar amend item #27per dr/wchd/4-Corondalesof Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year 0857 PHYLLIS WEST 2005 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Wicomica Regional Meder 591136411 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days Hours 1□ M 2₩ F 60 215-44-6939 MARYLAND JUNE 15, 1944 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No WICOMICO WILLARDS MARYLAND 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7395 CANAL STREET 21874 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2X Married 1 ☐ Yes 2 ☑ No Specify: Specify: WHITE 3 Widowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) OWN HOME a HOMEMAKER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) RAYMOND MELSON GLADYS GRAVENOR 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7395 CANAL STREET, WILLARDS, MARYLAND 21874 GARY W. WEST, SR./HUSBAND 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Surial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) NEW HOPE CEMETERY 4/13/05 WILLARDS, MARYLAND 5, Other (Specify) 21. Signature of eral Service Licens 22. Name and Address of Facility HASTINGS FUNERAL HOME, SELBYVILLE, DELAWARE 19975 23a. Part1. Enter the disease, or complications that crused shock, or heart failure. List only one cause on each ine Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediata Cause (Final ASCVD resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐ Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed? 2 10 1 ☐ Yes 25. Was case referred to medical examiner?

1 Pres 2 No

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

Directo

þ

Completed

Be

**Funeral** 

Director

3

Maryland

NAVIS Itimore,

itam 27 is marked other then "natural", or itama 23a or 28e-f show other treumatic event, the Madical Examinar must be notified at

h and Mental F 99

permit. Pages 1 and 2 should be Department of Health and Mental importent: If Itam 27 is marked c eny injury or other treumatic eve some.

attending physicien and for use as the burial-transli been signed by

death.

To the Hospital within 24 hours e To the Funaral E

Director:

The law requires that the death certificate be executed

المارية المرتبي المرتبي المرتبي المرتبي المرتبي المرتبية

ģ

Examiner Physician/Medicai Completed Be Certification: To completely filled in by the

IF FEMALE:

27. Manner of Death

ecident

29b. Signature and title of certifie

1 Natural

3 Suicide

29a, Certifier

4 Homicide

2	6.	Place	of	Death	(Ch	eck	only	one)	
917.	4	□ Nu	rsir	ng Hom	10	5 🗆	Res	iden	9

6 ☐Other (Specify) 28d. Describe how injury occurred

1 ☐ Yes 2 ☐ No

1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number 45049)

29d. Date signed (Month, Day, Year)

4/13/05

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) REGIONAL PENINSULA 100 East CARROLL ST.

DR. CHRIS JNYDER

SALISBURY Md. 21801

State Registrar

Medical

31. Date filed (Month, Day, Year) APR 1 4 2005

5 Pending investigation

6 Could not be determined



Hospital: 1 ☐ Inpatient 2 ☐ F/Outpatient 3 ☐ DOA

28b. Time of Injury

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28a. Date of Injury (Month, Day Year)

and manner stated

32. Digistrar's Signature

		ļ	For State Registrar	State of I	Marylan	d / Depa	artment of H	lealth an Death	d Mental Hy	giene	5	14233
	Physici		1. Decedent's Name (First, Middle Gladys C.						2. Date of De Month April	ath	005	3. Time of Death 1:20 A M
	/Medic Examin		4a. Facility Name (If not institution,		er)		4b. City, Town, o	or Location of D		4c. County		1.20 A
			Holy Cross				S	ilver S	Spring			gomery
	Funeral Director	- 1	5. Social Security Number 579-09-1994	6. Sex 7. 1 ☐ M 2 ☒ F	Age (in yrs. 94	last birthday) Yrs.	If Under 1 Year Months Days		Vin. (Month, Da	th y, Year) 3, 1911		place (State or Foreign ntry) ash., DC
	and W		Usual Residence of Decedent  10a, State 10b, County			y, Town or Lo	ocation					10d. Inside City Limits
	Maryli -1 sho fied a	tor		tgomerv		,,		ilver S	Inrina			1 ☐ Wes 2 ☐ No
	ith the or 286	Director	10e. Street and Number	LEOMELY			10f. Zip Code	TIACT D	pring	10g. Citizen of	What Cour	ntry?
	eath w	eral	10000 Bru	nswick Ave		5 12	Was Danadast of I	20910	2 (Sasaita Van an Na		ted S	States
က္	after de or item runer	Funeral	1 ☐ Never Married 2 ☐ Marrie	Armed Force ed 1 ☐ Yes 21	s?		_		? (Specify Yes or No uerto Rican, etc.)	Bla	ick, White,	etc.
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23s or 28s-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.	d by	3 Widowed 4 □ Divorced	Year or Date			1 ☐ Yes 21/2 No			Specif		Black
15	n "nat	Completed	15. Decedent' (Specify only highes Elementary/Secondary (0-12)	t grade completed)		(Give	dent's Usual Occup kind of work done DO NOT use retire	during most of	working	16b. Kind of B	usiness/In	dustry
212	ed with ygiene ier tha t, the	Com	_12th	College (1-4	or 5+)		Patent				overn	ment
and	otal Hi	Be	17. Father's Name (First, Middle, L					18. Mother's	Name (First, Middle,			
ž,	should nd Me mark matic	ို	Willia: 19a. Informant's Name/Relationsh			19b. Maili	ng Address (Street	and Number o	DOTOT r Rural Route Number	hy Vaug		Code)
	and 2 valth a 1 27 is er trau		Henry Cole -	Brother		531	Randolph	Rd., #	136A, Sil	ver Spr	ing,	MD 20904
Baltimore,	ges 1 of He if item or oth		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation	3 □Removal from Sta		Place of Dispo cemetery, crea	sition (Name of matory or other pla	ce)	Date	20c. Location	- City or To	own, State
Itim	iit. Pa artmen ortant: injury i.		* 4 ☐ Donation 5 ☐ Other (Sp 21. Signature of Funeral Service L		Lin		iemorial 2. Name and Addre				tland	
Ba	permi Depa Impo any ii		DAGUN T	Stewary	TIT	_			Stewart I., N.E. W			
			23a. Part L. Enter the disease, or shock, or heart failure. List of	complications that cau	sed the death	h. Do not ent					-	Approximate Interval Between
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	d			ılar Acci	dent				Onset and Death
ı	Examiner			Hv	as a conseq perten							
	pe sit	Iner	Sequentially list conditions, if any, leading to immediate		as a conseq							
	xecute and	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c	as a conseq	uence of):						
8760,	cate be executed physician and the burial-transit			d								
9	certifica nding ph use as th	Physician/Medical	IF FEMALE:	72a If uga auton	m a of overno							
Вох	eath atte for	clan	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outco	2 ☐ Feta	Ideath 3	Ectopic pregnancy Other (specify)	у			ate of delive onth	ery Day Year
P.O.	that the ded by the detached	hys	9 Unknown	9□ Unknow								
Ś	S C G	by	Part II. Other significant conditio	ns contributing to deat	h but not res	ulting in the u	nderlying cause giv	ven in Part I.				he cause of death?
COL	> 00	ompleted							24a. Was			psy findings available
Vital Record	o ~ 6	Comp	,							rmed?	prior to coldeath?	mpletion of cause of 2☐ No
/ita	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospitals 77					Death (Check only o	one)		
o	Phys this ral dis	: To	1 ☐ Yes 2 🔀 No 27. Manner of Death	Hospital: 1 Mnp 28a. Date of I		ER/Outpatier 28b. Time of	-	4 🗆 Mursii	ng Home 5 Resident	dence 6 Oth		ý)
ion	Attending F r death. sctor: After by the funer	atlor	1 X Natural 5 ☐ Pending 2 ☐ Accident investig	ation	Day Year)	Injury	Wor	rk?  Yes 2∐No				
Division	or Attendate deat Director: in by the	ertification:	3 Suicide 6 Could n 4 Homicide determi	ned 286. Place of	Injury - At ho etc. (Specif	ome, farm, str	eet, factory, office		28f. Location (S City or Tov	Street and Numb vn, State)	er or Rura	al Route Number,
_	pital ours ours illed	O	29a. Certifier 1 Certifying	g Physician: To the be	est of my kno	wiedge, deati	h occurred at the ti	me, date and pl	lace, and due to the	cause(s) and ma	anner as s	tated.
	- (7 - 10	ledical	One)	examiner: On the basi and manner	s of examina	tion and/or in	vestigation, in my o	pinion, death o	occurred at the time,	date and place,	and due to	the cause(s)
1	To the within 2 To the complete	Σ	29b. Signature and little of certifier		7/		29c. Licens	se number 10013231		29d. Date signe		Day, Year) 0, 2005
	(2)		30. Name and address of person v	who completed cause	of death (Item	n 23a) (Type		.0019231		Whr	TT 1(	, 200J
_	9		Thomas Pi	nder, M.D.	1160	) Varnu	ım St., N	I.E. Was	sh., DC 20	017		
	Sta Registr	916	31. Date filed (Month, Day, Year) APR 1 3 20	105 2. Reg	istrar's Signa	iture	W					

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2, Date of Death 3. Time of Death Year **Physician** John Raymond Wright, Sr. April 09, 2005 /Medical 09:30 PM 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Allegany 228 Centennial Street Frostburg 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 6. Sex **Funeral**  Birthplace (State or Foreign Country) Months 1**⊠**M 2□F Days Hours Min Yrs. Director 214-16-2034 01-Dec-1922 **Maryland** Usual Residence of Deceden iiled within 72 hours after death with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 27 s marked other than "natural", or Itams 23e or 28e-f shov traumatic event, the Madical Exandrer must be notified at 1₽Yes 2□No Director Maryland Allegany Frostburg 10e. Street and Number 228 Centennial Street 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 21532-U.S.A 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☑Yes 2 ☐ No
If Yes, Give
Year or Dates: WW I 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify: 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) school bus company driver 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Thomas Wright Margaret Brode 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If itam 27 Is m 228 Centennial Street Ruby Wright wife Frostburg Maryland 21532 othar 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State any injury once. '4 Donation 5 Dother (Specify) Maryland Veteran's Cemetery 13-Apr-2005 Flintstone 21. Signature of Funeral Service Licent 22. Name and Address of Facility ohn Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 23a. Pay. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, rock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician UNG (ano disease or condition resulting in death) uca /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events Examiner Due to (or as a consequence of) The law requires that the death certificate be executed ed by the attending physician and detached for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown s certificate has been signed by lirector, page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed? 1 Yes 2/2 No or Attanding Physician: funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 esidence 6 Other (Specify) 1 ☐ Yes 2 Z No Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Director: After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident the 6 Could not be 3 🗀 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours e To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and granner stated. Medical 29b. Signature and title of certifie To D-36766 Print) Print) Print) Print) 2 Print) 2 Print) 2 Print) 2 Print) 2 Print) VA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Poorai, M.D., Vikramadit n12 va 32. Registrar's Signature State

DHMH 17 Rev 1/2001

'Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

2005

Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** RUTH ELEANOR WHITE 3, APRIL 2005 1:33 AM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner DEVLIN MANOR NURSING HOME CUMBERLAND ALLEGANY If Under 1 Year If Under 24 Hrs. Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days 1 M 257F Vrs Director 214-07-4646 88 30,1917 MARYLAND Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinar must be notified at 1 Yes 2 No MD Director ALLEGANY CUMBERLAND 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 405 BEALL STREET 21502 Funerai U.S.A.

14. Race - American Indian, 11. Marital Status 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) permit. Pages 1 and 2 should be filed within 72 hours effer to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural". or than shy fijury or other trainment. Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1X Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 X No Specify: δ Specify: 3 Widowed 4 Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) FACTORY WORKER CELANESE CORPORATION 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ERNEST J. WHITE HAZEL DAYTON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) GARY L. WHITE / NEPHEW 519 FAYETTE STREET, CUMBERLAND, MD 21502 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) HILLCREST BURIAL PARK 04/06/2005 CUMBERLAND, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility UPCHURCH FUNERAL HOME, P.A. 202 GREENE STREET, CUMBERLAND, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Betw Physician Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to/(or as a consequence of): Examiner The law requires that the death certificate be executed attending physician end for use as the bunal-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or es e consequence of): Box 68760. Physician/Medical Due to (or as a consequence of): resulting in death) Last P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, δ 99 Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? has 1□Yes 2∃No 1 ☐ Yes 2 ☐ No certificate or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4⊟Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) Medical Certification: 28b. Time of 28d. Describe how injury occurred After 5 Pending investigation 1-Natural ofter death.

Director: Aft
in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide To the Hospital or within 24 hours of To the Funeral D 29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

nes

State Registrar

31. Date filed (Month, Day, Year) APR 0 5 2 2005

AJ



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Bullin

DUU17565

626212

4, 2005

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Vanessa Dale Sanders Williams 2005 3:30 P. M 5,\_ April /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Prince Georges 8409 Hamlin Street; Apt. 203 Lanham 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Yeal 956 **Funeral** 1 ☐ M 2 🗙 F 577-76-7691 49 Director January 28, Washington, D.C Usuel Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 28e-f ehov the Medical Examiner must be notified at 1 X Yes 2 ☐ No Director Prince Georges Lanham Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with or items 23a or 8409 Hamlin Street; Apt. 203 20706 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status illed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No if Yes, Give Year or Dates: Specify: Specify: Black þ 3 Widowed 4 Divorced "naturai". Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed we Depertment of Health and Mental Hygien Important: If item 27 is marked other the eny injury or other traumatic event, the once. 12th grade Cashier Toys R Us Stores 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Harry Sanders Mary Kendrick 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Henry Lee Williams Jr.; (Son) 8409 Hamlin Street; Apt. 203; Lanham, Maryland 20706 April 11,2005 20c. Location · City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) George Washington Cemetery Adelphi, Maryland 21. Signature of Funeral Service Icense 2. Name and Address of Facility
R. N. Horton Company Morticians, Inc.
600 Kennedy Street, N.W.; Washington, D.C. 20011 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** arcinomo resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed use as the burial-tran and Due to (or as a consequence of) P.O. Box 68760. the attending physicien Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy jo in the past 12 months? Day Year 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, ate has been significated be page 2 should be 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? res 2 No certificate 1 ☐ Yes 2 ☐ No 1 Yes or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death Check on one Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5X Residence 6 Other (Specify) Certification: To 1 Yes 2 X No 2 ER/Outpatient 3 DOA this ē 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 X Natural 5 Pending after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifie 2 Medical Examine 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 45660 7,2005 April 30. Name and address of person who completed cause of seath (Item 23a) (Type, Print) Dpinder Singh, M.D.; 14300 Gallant Fox Lane; Suite 124; Bowie, Maryland State 1 2 2005 Registrar

			1 - For State Registrar	State of M	Maryland /		artment rtificate			and M	.*	gien <b>e</b> Reg. No.	005	14237
	Di		1. Decedent's Name (First, Middle, Last)			-				. 1	2. Date of De. Month	ath Day	Year	3. Time of Death
	Physici /Medio		Patricia Ann	Wilson	1						April	19	2005	8:30 P M
7	Examin	er	4a. Facility Name (If not institution, give s				4b. City, 1						ounty of Death	
			Harford Memorial			1:41 1 1			Gra				rford	
	Funeral Director		5. Social Security Number 6. Sex	M 2∏F	Age (In yrs. last 66	Vrs.	Months	Days	Hours	Min.	8. Date of Birt (Month, Da	v, Year)	Cour	
			213-46-4015 Usual Residence of Decedent								11/22/	38	Mar	yland
	how how		10a. State 10b. County		10c. City, To	own or Lo	cation						1	0d. Inside City Limits
	Se-fs	Director	MD Harford	1	Aber	deen								1 ☐ Yes 2Ã No
	or 24	Dire	10e. Street and Number				10f. Zip	Code				10g. Citizer	n of What Cour	ntry?
	s 23s	rai	304 Stockhams La		.5			2100					S.A.	
36	72 hours after death with the Maryland "naturel", or Items 23a or 28e-1 show offsel Examinat must be notified at	by Funeral	11. Marital Status  1★ Never Married 2 Married  3 Widowed 4 Divorced	2. Was Deceder Armed Force 1 ☐ Yes 23 If Yes, Give	ss? ∑No	- 1	Was Decede If Yes, spec 1 ☐ Yes 2		spanic Ori n, <b>Me</b> xicar Specify:	gin? (Spe i, Puerto	cify Yes or No Rican, etc.)		Race - Americ Black, White, Decify: Whi	etc.
21215-0036	ture!		15. Decedent's Educ	Year or Date		6a. Dece	dent's Usua	I Occupa	tion			16b Kind	of Business/Inc	
15		Completed	(Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4c		(Give	kind of wor DO NOT us	k done di	uring mos	t of worki	ng	TOO. TAITO	01 003111033/1111	addity
212	filed within Hygiene. other than "	E O	12	0	) S+)	Flor	al De	sign	er			F]	lorist	
B	al Hygie I other vent, III	Be	17. Father's Name (First, Middle, Last)	•							(First, Middle,		ımame)	
Maryland		ဂ္	Harold R. Wilson	ו					Ger	rtruc	le Kelle	er		
Jar	s 1 and 2 should 1 Health and Mer item 27 is marks other treumatic		19a. Informant's Name/Relationship (Typ										own, State, Zip	
	1 and 2 Health tem 27		Douglas S. Wilson 20a. Method of Disposition	(brothe			North		Rd.		berdeer	-	cyland tion - City or To	21001
ъ	8°= 5		1 Surial 2 Cremation 3 □R	amoval from Sta	te ceme	itery, crer	natory or ot	her place	·	- 1/23/				
Baltimore,	nit. Pa pertmen cortent: injury		<ul> <li>*4 □ Donation 5 □ Other (Specify)</li> <li>21. Signature of Funeral Service License</li> </ul>	е	PIC	-	Cemer  Name and	_	_		05	Del F	Air, Ma	Lytand
Ba	permit. Depirti Import anyinj		* Kirkn Allo	sterk	M	$\mathbf{T}$	arrino berde	q-Ca:	rqo E	uner	al Home 21001-	P. P. P	<i>A</i> •	
	5		23a. Part1. Enter the disease, or complice shock, or heart failure. List only on	ations that caus	ed the death. D									Approximate Interval Between
JU,	Enysician		Immediate Cause (Final disease or condition	Cause on yac	most	ive !	Hour	++	ula	1 10			1	Onset and Death
	/Medical		resulting in death)	Due to (o)	as a consequin	e of):	FCEV	11	()	CIC				nu
	Examiner		Sequentially list conditions, b	_()	or V	ulu	nonu	de.	- 1				5	y lang
V	ted nsit	Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to	as a consequent	ce of):	(1	00 0	1	1			0	
	and al-tran	хап	that initiated events resulting in death) Last	Due,tovor:	C TVUCT	ce of):	>(4	ey	17	/wee	ζ.			70000
8760	cate be executed ohysician and the burial-transit	dicalE		Ob	PCIL	,							2	OSONIC
687	ificate g phy as the	O I												100.2
Вох	The law requires that the death certificate be executed to has been signed by the attending physician and oage 2 should be detached for use as the burial-transit	Physician/M	200. Has decedent pregnant		me of pregnancy		Ectopic pre	agnancy				230	d. Date of delive	ery
	e deal	sicis	in the past 12 months? 1 Yes 2 □ No		at time of death		Other (spe						Month	Day Year
P.O	that the de led by the a detached i	Phy	9 Unknown	1		a in Abrasia	- 4 4				222 Did 4			ne cause of death?
S,	ires tha signed d be de	by	Part II. Other significant conditions con	lon de de	/ Dut not resultin	g in the u	nderlying ca	iuse give	n in Part i.			os 2□1		
Ö	w requir	etec	y turerest	MERCHAN	· · · · · · · · · · · · · · · · · · ·									
Records,	has be 2 s	Completed									24a. Was autop perfo	an 2 sy med2	prior to cor death?	psy findings available apletion of cause of
Vital		e Co	25. Was case referred to medical				···		66 PI		1 Yes	2 No	1 🗆 Yes	2 No
5	Physician: this certific al dire tor,	0 8	examiner?	ospital:	atient 2□FR/	Outpatier	nt 3 DO	Othe	r.		(Check only o		Other (Specify	()
J Of		T:U	27. Manner of Death	28a. Date of Ir		b. Time of		Bc. Injury Work	at		28d. Describe			·/
jor	Attending or death. ector: After by the fune	atio	Natural 5 Pending Investigation	(WOINI, I	Day (Bal)	Injury	М		es 2 🔲	No				
Division	r Atte	Certification:	3 Suicide 6 Could not be determined		Injury - At home etc. (Specify)	, farm, str	eet, factory,	office		2	28f. Location (S City or Tox		lumber or Rura	l Route Number,
	urs af urs af rel D													
	Hosp 24 hou Fune tely fi	edical	29a. Certifier Certifying Physics (Check only 2 Medical Examinone)	er: Of the basis	s of examination	dge, death and/or in	n occurred a vestigation,	at the time in my opi	e, date an inion, dea	d place, a th occurre	and due to the e	ause(s) and pla	d manner as st ace, and due to	ated. the cause(s)
	To the Hospitel or Attent within 24 hours after deatl To the Funerel Director: completely filled in by the	Med	29b. Signature and like of continer	and manner	stated.		29c.	License	number			294. Date s	igned (Month,	Day, Year)
	⊢ 3 ⊢ ŏ		11/1	1	- no 6	2		420	797	7	. 1	Lona	1)0	2005
	6		30) I'mp d address of person who co	npleted cause o	of death (Item 23	a) (Type.	Print)	1	/	1 11		(1103		
			Beten Lovesti, i	O FAR	P 1308	SBI	15 NE	.s ()	ent	er ll	ly Ka	accur	d M	7.
	Sta	- 1	31. Date filed (Month, Day, Year)	100	strar's Signature	1	<b>.</b>			1	/			
	Registi	ar	APR 2 6 200	15 / 10-	and A	1	2000 0							

				For State Registrar		State o	f Maryla		artmen <i>rtificat</i>				ental Hyg	giene Reg. No.	005	14238
_	I		1. Decedent's Name (First, Middle, Last)  Physician /Medical  JAMES E • WORKMAN									2. Date of Dea Month April	ith Day	2005	3. Time of Death 7:52P M	
		/Medic Examir		4a. Facility Name (I		give street and nu				Town, o	r Location	of Death	APITI		ounty of Deat	
		Funeral Director		5. Social Security N 205–16–6		.Sex 1 <b>X</b> M 2 □ F	7. Age (In yrs	. last birthday) Yrs.	If Under Months	1 Year Days	If Unde Hours	r 24 Hrs. Min.	8. Date of Birth (Month, Day 3/24/1	7, Year) 927		nplace (State or Foreign untry) St Virginia
		ס		Usual Residence o	10b. County	المسر		ity, Town or Lo		C 3			0/21/1	32,	,,,,,,	10d. Inside City Limits
ત		death with the Marylan ms 23s or 28s-f show Imast ke nyiffied at	Funeral Director	MD 10e. Street and Nu	Harfo				White					10g. Citizei	n of What Co	1 ☐ Yes 2 X No untry?
10		23a	ai	4531 F	lintvil1	Le Road		•	21	160					USA	
/6/	9036	ours after ral', or ite	þ	11. Marital Status 1 ☐ Never Marr 3 ☑ Widowed	ried 2 Marne 4 Divorced	Armed Fo	2 📉 No ve		Was Deced If Yes, spec 1  Yes	cify Cuba	dispanic Oan, Mexica Specify	ın, Puerto P	cify Yes or No- Rican, etc.)		Race - Ame Black, White pecify: Whi	e, etc.
	5	72 hours "natural", dice En	etec	(Spec	15. Decedent's cify only highest	Education grade completed)		(Give	dent's Usua kind of wo	rk done	durina mo.	st of workin	g	16b. Kind	of Business/I	ndustry
	21215-0036	s 1 and 2 should be filed within 72 hd I Health and Mental Hygiene. Item 27 Ia marked other than "natur other traumatic event, the Medicel	Completed	Elementary/Seco	ondary (0-12)	College (	1-4or 5+)	1	pente:						tructi	lon
,U	Maryland	should be fill and Mental H a marked off	To Be	James P	(First, Middle, La atrick V	,	·						(First, Middle, Le Bald		ımame)	
12/0.		and 2 sho salth and n 27 la m		James W	orkman/S			249 1	Macon	Pri			Route Numbe Barysbu			
7/	Baltimore,	g ° = 5				□Removal from cify)	State	Place of Dispo cemetery, cred 1 Air Me	matory or o	ther plac		4/21/	/2005		tion - City or T	
	Balt	permit. Pag Department Important: any Injury o		21. Signature of Fu	uneral Service Li	ensee	7	Ha	2. Name an	d Addre F <b>uner</b>	ss of Facil	me,Inc.	,600 Mai	n St.,	Delta,	PA 17314
436299	68760, <	Exam be executed // Medical ending physician and attending physician and for use as the burial-transit	edical Examiner	spece, or reading cause disease or condition resulting in death)  Sequentially list confirm, leading to incause. Enter Under Cause (Disease or that initiated events resulting in death)	(Final on on on on on on on on on on on on on	b. Due to	(or as a consector of consector	quence of):	70Cu	rdu	à (	Int	arctio	<i>~</i> 1		Interval Batween Onset and Death  // minutes
#	.O. Box	requires that the death certif een signed by the attending hould be detached for use a	Physician/Me	IF FEMALE: 23b. Was deceden in the past 12 1 ☐ Yes 2 { 9 ☐ Unknown	? months? □ No		ointh 2 Fet nant at time of	al death 3	Ectopic pr Other (sp		,			230	I. Date of delin Month	v <b>ery</b> Day Year
63	rds, P	n requires that the di been signed by the should be detached	by	Part II. Other signi	ficant condition	s contributing to d	eath but not re	sulting in the u	nderlying c	ause giv	en in Part	l,				the cause of death?
ame	Vital Records,	e law has b	Completed										24a. Was a autops perfor	in 2 sy med?	24b. Were aut prior to c death? 1 \sum Yes	opsy findings available ompletion of cause of
0	ita	lcian: Th certificate rector, pag	a)	25. Was case refer	rred to medical						26. Plac	e of Death	(Check only or			
			To B	examiner? 1 ☐ Yes 2 ☑	No	Hospital: 1 🗆	Inpatient 2	PER/Outpatier	nt 3 DC	A Oth	er: 4 🗆 N	ursing Hom	e 5 🗆 Reside	ence 6	Other (Spec	ify)
orkman	Division of	ath. or: After the		27. Mann of Deat  1 Natural 2 Accident	5 Pending investiga	tion	of Injury th, Day Year)	28b. Time o Injury	f 2	8c. Injun Worl		28	3d. Describe h			
Jrki	Divis	tal or Att	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could no determin	ad 28e. Place	of Injury - At h		eet, factory	, office		28	Bf. Location (Si City or Town		lumber or Rui	al Route Number,
$\mathcal{E}$		To the Hospital or Attending Phywithin 24 hours after death. To the Funeral Director: After this completely filled in by the funeral discompletely filled in by the funeral discompletely filled in by the funeral discomple	edical	29a. Certifier (Check only one)	2 Medical Ex	Physician: To the aminer: On the b and man	best of my kn asis of examin ner stated.	owledge, deat ation and/or in	h occurred vestigation,	at the tin	ne, date ai pinion, dea	nd place, ar ath occurred	nd due to the c d at the time, d	ause(s) and pla	d manner as	stated. to the cause(s)
		To t To t	Σ	29b. Signature and	d title of certifier	15.	M D			D		0/2	1	April	igned (Month)	605
		8		30. Name and addr	ress of person wi		se of death (Ite	m 23a) (Type, Z	Print)	-14	A	10.	Bel	Air	, me	. 21014
		Sta Registr	• .	31. Date filed (Mon	APR 2 6		egistrar's Sign	ature								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 15 1- State Registrar amend item #12&15 per fh g844 nijoateos Grath 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year JOHN April 09, 2005 1:40 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Holy Cross Hospital Silver Spring Montgomery If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. | 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1**X** M 2□ F Yrs. 579-48-0114 72 08/14/1932 China Usual Residence of Deceden 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Prince George's Forestville 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 5902 Cheryl Lane 20747 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 N1953-54
If Yes, Give 1950-52 14. Race - American Indian, Black, White, etc. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No Specify: Asian Year or Dates: 1950 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) unk 6 Restaurant Owner Food 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) unk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Poy Y. Yee, Wife 5902 Cheryl Lane, Forestville, Maryland 20747 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) Ft. Lincoln Crematory 04/13/2005 Brentwood, Maryland 21. Signature of Fune al Service Lidensee 22. Name and Address of Facility Simple Tribute 1040 Rockville Pike, Rockville, Maryland 20852 23a. Part1. Enter the disease, or complications that caused the seath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Malignant Pleura disease or condition resulting in death) Due to (or as a consequence of): MONTHS adenocarcinoma Una Due to (or as a onsequence of): Due to (or as a consequence of):

**Physician** /Medical **Examiner** 

physician and s the burial-transit

certificate has be lirector, page 2 s

Physician: The law requires that the death certificate be executed

Box 68760

D.0

Records,

of Vital

Division

the Hospital or Attending

death.

after death Director;

filled 24 hours a

**Physician** 

/Medical

Examiner

10a, State

Director

Completed by Funeral

Be

unk

Funeral

Director

ir than "natural", or itama 23s or 28s-f show the Wedical Examinar must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or iten any highy or other traumatic event, the Medical Exami

Baltimore, Maryland 21215-0036

if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

23b. Was decedent pregnant

in the past 12 months? 1 ☐ Yes 2 ☐ No

23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 Ectopic pregnancy 4☐Pregnant at time of death 5 Other (specify)

23d. Date of delivery Dav

Physician/Medical Examiner þ

examiner

1 Natural 2 Accident

3 Suicide

29a. Certifier

4 Homicide

Be Completed

2

Certification:

Medical

IF FEMALE

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. Was an

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2. No 3 ☐ Probably 4 ☐ Unknown

autopsy performed? Yes 2 No 1 ☐ Yes

24b. Were autopsy findings available prior to completion of cause of death? 2□ No 1 Yes

25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year)

Cther: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

28c. Injury at Work? 28b. Time of 1 Yes 2 No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

investigation

6 Could not be determined

D 52503

29d. Date signed (Month, Day, Year)

204

within 24 ho To the Fund completely f

Registrar

SHAILESH

MD SHETH 1221

MERCANTILE LANE, LARGO

1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

			1 - For State Registrar	State of Mary		artment <i>rtificate</i>			nd M		iene	05	1, 2	40
	Physicia /Medic	al	Decedent's Name (First, Middle, La     GEORGIA     A     4a. Facility Name (If not institution, give	NGELIS		4b. City, To	own orl	ocation of	Death	2. Date of Dear Month APRIL	Day	Year 2005	3. Time of 02//	
	Examin Funeral	er	LUASHINGTON ADVEN 5. Social Security Number 6. S	T(ST HOSPITA ex 7. Age (In	yrs. last birthday)	TAKE	VA A		MA	8. Date of Birth (Month, Day, 10/13	MON	7 GOME	place (State o	or Foreign
	Director 28a-f show	)r	578-52-0203   Usual Residence of Decedent   10b. County   Montgon	100	City, Town or Lo	ocation				10/13	/1939		od. Inside Ci	ity Limits
	h with the M 3a or 28a-f	Funeral Director	10e. Street and Number 2722 Weller Ro			10f. Zip C	ode 090	6		1	0g. Citizen of	What Coul		
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Importent: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examination into the rolling at once.	þ	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever Armed Forces? 1  Yes 2 No If Yes, Give Year or Dates:	1	Was Decede		panic Orig , Mexican, Specify:	in? (Spe Puerto	ecify Yes or No- Rican, etc.)		ce - Americk, White,		
Baltimore, Maryland 21215-0036	ed within 72 ho giene. er than "natur , the Medical	Be Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0·12)		(Give	dent's Usual kind of work DO NOT use ecret	done du retired)	ıring most	of worki	ng	16b. Kind of B		dustry	
ryland	should be file nd Mental Hy s marked oth umatic event	To Be (	17. Father's Name (First, Middle, Last Vasilios Stavi	coulas	10b Mail	ag Addross (		Para	ske	ve Bak	ola		6-4120	0.04
re, Ma	ss 1 and 2 soft Health an item 27 Is 1		Nicholas Ange	lis/Son	1 2 1	39 Tu	rns	tone	Co	urt Si	lver	Spri	ng,Md	904
Baltimo	permit. Page Department of Importent: If any injury or once.		1 Surial 2 Cremation 3 4 Donation 5 Other (Specification 21. Signature of Juneral Service Lices	2	Gate of	f Heav	ven Address	4 RTN2	LDI	/2005 S FUNER vd.Sil	AL SE	RVIC	E,P.A	
8760,	Physician /Medical Examiner  buyasicien and sthe parial-transit	dicai Examiner	23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b.  Due to (or as a cord.)   nsequence of): ENAL FA	AST C			eardiac o	r respiratory arre	est,		Approximatinterval Bet Onset and Is 5 Year	Death S	
P.O. Box 6	To the Hospitel or Attending Physician: The law requires that the death certific within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the ettending p completely filled in by the funeral director, page 2 should be detached for use as in	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pr 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3	□Ectopic preg □ Other (spec						te of delive	,	/ear
	w requires that been signed t		Part II. Other significant conditions of Cloytvidium difficulty	ontributing to death but no	t resulting in the u	inderlying cau	se giver	n in Part I.		23e. Did tob	s 2 No		ne cause of d	
al Rec	ician: The law certificate has b	Completed by									ged? ZINo	prior to co death?	psy findings and pletion of care	available ause of
Division of Vital Records,	iding Physician: th. : After this certific funeral director.	tion; To Be	25. Was case referred to medical examiner?  1  Yes  No  27. Manner of Death 1 Natural  5 Pending investigatio	28a. Date of Injury (Month, Day Yea	2 ER/Outpatier 28b. Time o Injury		Other Linjury a Work?	4 🗆 Nur	sing Hor	(Check only only only only only only only only	nce 6 Oth		/)	
Divisi	To the Hospitel or Attending Phwithin 24 hours after death. To the Funeral Director: After the completely filled in by the funeral	Certification;	3 Suicide 6 Could not b determined		At home, farm, str	reet, factory, o	_			28f. Location (St. City or Town		per or Rura	l Route Num	ber,
	To the Hospite within 24 hours To the Funeral completely filled	Medical	29a. Certifier (Check only one)  1 Certifying Properties one)  29b. Signature and title probatilier	ysician: To the best of my niner: On the basis of exa- and manner stated.	r knowledge, deat mination and/or in	vestigation, ir	the time my opin	nion, death	place, a	ed at the time, da	tuse(s) and ma te and place, Od. Date signe	and due to	the cause(s	)
	1		30. Name and address of person who	Completed cause of death	(Item 23a) (Type,		0611	007	0		April	22,	2005	
	Sta Registr		Kenneth Khandagle 31. Date filed (Month, Day, Year)	32. Registrar's 8	. University	Blvd \$	25	Vilvei	Jpv	ing, MD	20403			

05-2745 B.K.S							c. Ensure All	•	•	
ARNOLD	L. AL	PEF	T For State Registrar	State of M		epartment of Certificate of	Health and Me Death	ental Hygie Reg.	ZUHA	14241
	Physicia /Medic		1. Decedent's Name (First, Middle, La Arnold Leon	ard A	lpert				Day Year 9, 2005	3. Time of Death 0715 A M
	Examin		4a. Facility Name (If not institution, giv 5151 POOKS HILL	ROAD		BETHESI			4c. County of Deat MONTGOME	
	Funeral Director		100 01 1120		ge (In yrs. last birth	rs. If Under 1 Years. Days		Month Day, Ye an 23, 1	9. Birt 944 New	thplace (State or Foreign Dupty) York, NY
Maryland	of show filed at	tor	Usual Residence of Decedent  10a. State 10b. County  CA Los An	geles	10c. City, Town Los An					10d. Inside City Limits 1 ☐ Yes 2 No
th with the	23s or 28e	Funeral Director	10e. Street and Number 8514 Franklin Av	enue	-1	10f. Zip Code 9006	9		Citizen of What Co	untry?
1215-0036 within 72 hours after death with the Maryland	Department of Health and Mental Hygiene. Important: or items 23s or 28e-f show any injury or other traumatic event, it a Modical Exeminer must be notified at once.	P S	11. Marital Status  1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced	12. Was Decedent Armed Forces? 1  Yes 2  If Yes, Give X Year or Dates:	No I	13. Was Decedent of If Yes, specify Cu	Hispanic Origin? (Specban, Mexican, Puerto R	ify Yes or No- ican, etc.)	14. Race - Ame Black, Whit Specify: W]	e, etc.
Baltimore, Maryland 21215-0036	giene. er then "natu tre Modical	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)	ducation ade completed) College (1-4or	5+)	Decedent's Usual Occu Give kind of work don life. DO NOT use retir Owner	during most of working	Wh	o.Kind of Business/ colesale s crble	
yland y	Mental Hyg arked othe stic event,	To Be C	17. Father's Name <i>(First, Middle, Last</i> Nathan Alpert	)			18. Mother's Name (		den Surname)	
Var 12 sho	h and 7 is mu		19a. Informant's Name/Relationship ( Caryn Alpert	<sub>Турө, Print)</sub> (Daughte			ntand Number or Rural. rly Drive H			
more, I	not of Healt int: if item 2 iry or other		20a. Method of Disposition  1 Burial 2 Cremation 3 C  4 Donation, 5 Other (Specia	Removal from State	20b. Place of I	Disposition (Name of , crematory or other pl. ai Mem. Pa	ace) Da	te 20d	Location - City or os Angeles	Town, State
Balt.	Departn Imports any inju		21. Signature Funeral Service Life	20000	200	Mt. Sinai 5950 Fore	ress of Facility Mortuary st Lawn Los	s Angeles	s, CA 900	68
	nysician /Medical	(	23a. Pa 1. Enter the disease, or consoler the disease, or heart failure. List only limited the disease or andition resulting in death)				ing, such as cardiac or Wous Scular disc			Approximate Interval Between Onset and Death
	xaminer Jausit	amlner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, (Disease or injury	b. Atherosc Due to (or as	cle rotic	ecerdiora	scular dis	euse		
68760, iilicate be execu	attending physicien and for use as the burial-train	Ш	that initiated events resulting in death) Last	c	a consequence of	·):				
ords, P.O. Box 68760,	y the attending priched for use as	Physiclan/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	23c. If yes, outcome 1 Live birth 4 Pregnant a	2 Fetel death	3 ☐ Ectopic pregnants ☐ Other (specify)	су		23d. Date of deli Month	ivery Day Year
rds, P	been signed by the should be detached	þ	Part II. Other significant conditions	contributing to death b	out not resulting in	the underlying cause g	iven in Part I.	23e. Did tobacc		the cause of death?
I Rec	ate has b	Completed						24a. Was an autopsy performed	prior to death?	topsy findings available completion of cause of
of Vita Physician:	certifi	Be	25. Was case referred to medical examiner?	Hospital:		- 0	26. Place of Death (			S Section Accesses 2
Division of	al d	ation: To	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Inju (Month, Da		me of 28c. Injury	4   Nursing Home	e 5 Residence d. Describe how in	e 6 Other (Special of the Control of	AT SCENE
Divis	s after de ai Directo ed in by th	Certification:	3 Suicide 6 Could not to determined	286. Place of in	jury - At home, farr tc. <i>(Specify)</i>	n, street, factory, office	28	f. Location (Street City or Town, St	t and Number or Ru tate)	ral Route Number,
the Hospital	in 24 hour the Funer. pletely filk	Medical (	29a. Certifier 1 Certifying Pt (Check only one) 2 X Medical Example 1	nysician: To the best miner: On the basis o and manner st	of examination and	death occurred at the for investigation, in my	time, date and place, an opinion, death occurred	d due to the cause I at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)
9	To Too	2	29b. Signature and title of certifier			29c. Licer	ise number	29d.	Date signed (Month	i, Day, Year)

State Registrar Josha Jeensey M. D.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

OSha Z Giveenberg M. D.

31. Date filod (Month, Day, Year)

32. Registrar's Signature

A Cause of dear Them 23a) (Type, 1 min)

32. Registrar's Signature

OCME

20, 2005

APRIL

111 Penn Street Baltimore, Maryland 21201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
item#12.perfH.G043,5/5/05 TT
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** 05 /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner of muy ho Medical 134/ 5 mong NA 6. Sex 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day) 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign Days Hours Min 1X M 2 | F Yrs. Director 212-36-6037 69 12-26-1935 MARÝLAND Usual Residence of Decedent 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show treumatic event, the Medical Examiner must be notified at Director 1 ☐Yes 2 ☐ No WEST RIVER MD. ANNE ARUNDEL 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a 5271 SUDLEY RD. 20778 USA Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 Ayes STINO If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after 1 Never Married Married Baltimore, Maryland 21215-0036 ò 1 ☐ Yes 2 ☐ No Specify: BLACK ģ 3 Widowed 4 Divorced 'natural', Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Dccupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry WASHINGTON SURBURBAN and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) MAINTENANCE UTILITY LOCATOR SANITATION COMMISSION -12--0-17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be THOMAS ABEL MARGARET EASTON ဨ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) WEST KINER MD. 20778 BESSIE M. ABEL(WIFE) SYDLEY KD. item 27 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages
Department of I
Importent: If It
any injury or o
once. 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State ZION CHURCH CEMETERY 4-25-2005 LOTHIAN, MARYLAND \* 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of FacilityWM . REESE & SONS MORTUARY, P.A. 21. Signature of Funeral Service Licensee 821 WEST ST. ANNAPOLIS, MARYLAND 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical **Examiner** ENTERIOR APPROVED BY MEDICAL EVALUATER Sequentially list conditions, Due to for as a consequence of, Examiner ally, leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, physician Physician/Medical IF FEMALE: If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 2 Fetal death in the past 12 months?
1 Yes 2 No Month Day 4☐Pregnant at time of death 5 Other (specify) 9☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown Completed 24a. Was an autopsy performed? 1 ☐ Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 1 Yes or Attending Physicien: Be 25. Was case referred to medical 26. Place of Death Check onl one examiner's Hospital: 1 XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 2 1 ☐ Yes 2 ☐ No 4 Nursing Home 5 Residence 6 Other (Specify) in by the funeral 28c. Injury at Work? 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred Certification: After Natural 5 Pending death. 2 Accident 3 Suicide CS Vakrow AM 1 ☐ Yes 2 🖫 No Fell down ships investigation after death Director: / 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide home 2271 To the Hospitel within 24 hours a To the Funerel D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifie 29d. Date, signed (Month, Day, Year) Marino 60042 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) R. Adms Cowlex Shock Troum Center MI MARINARO 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene 🕦 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death April 18, 2005 **Physician** Rose Caroleo Burke 910AM № /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Future Care Chesapeake Anne Arundel Arnold | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months Days Hours Min. | 4 Pril 7, 1912 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign 1 ☐ M 2 🙀 F Yrs. 211-09-8199 93 Pennsylvania Director Usual Residence of Decedent 2 should be illed within 72 hours after death with the Maryland and Mental Hygiene.
Is marked other then "natural", or Itams 23e or 28e-f show 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits Itam 27 is marked other then "natural", or Itams 23a or 28e-f show other traumatic event, it is Medical Eventral the rediffical at 1 ☐ Yes 2 No Director Maryland Anne Arundel Arnold 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 14 Sheridan Road 21012 United States Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 to Yes 2 □ No If ♣es, Give Year or Dates: WWI Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 Never Married 2 Married WWII Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify Specify: 3 X Widowed 4 □ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Clerk Retail Sales 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ဂ္ Joseph Caroleo Mary Swyk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If Itam 27 is m any Injury or othar traum once. Gaithersburg, Clifford D. Burke . Son 324 Hart Mews MD 20818 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify),
1. Signature of Euphys Service Libensee Chartiers Cemetery 04/22/05 Pittsburgh, Pennsylvani 21. Signature of Fur 22. Name and Address of Facility Harman Funeral Service, P.A. M01113 7221 Grayburn Drive, Glen Burnie, MD 21061 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 10515 disease or condition resulting in death) /Medical Due to (or as a conse **Examiner** n Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner been signed by the attending physician and should be datached for use as the burial-transit The law requires that the death certificate be executed resulting in death) Last Division of Vital Records, P.O. Box 68760, Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 2 Fetal death 3 Ectopic pregnancy Month Day Year 5 Other (specify) 4☐Pregnant at time of death 1 ☐ Yes 2 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform weign 2 No 1 Yes or Attanding Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one, examiner? 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manger of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Attar Natural 5 Pending 2 Accident death. investigation 1 ☐ Yes 2 ☐ No Director 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funaral E

completely tilled i To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 39 lame and address of person who completed cause of death (Item 239) (Type 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar

			For State	tate of Maryland / [				lental Hy	giene		
			Registrar  1. Decedent's Name (First, Middle, Last)		Ceni	ficate of L	Jeath		Reg. No.	2005	1421
	Physicia	ın						2. Date of Dea Month	Day	Year	3 Time of Death L
	/Medic	al	Harold  4a. Facility Name (If not institution, give stre	Bryant		th City Town or	Location of Death	April 3		2005	9:20 A M
	Examin	er		arano number)	•				1	County of Death	
	Funeral		352 Greenlow Road 5. Social Security Number 6. Sex.	7. Age (In yrs. last bit	rthday)	Catonsv If Under 1 Year	If Under 24 Hrs.	8. Date of Birt	h		lace (State or Foreign
	Director		217–26–2386 ¹¾ <sup>M</sup>	<sup>2□ F</sup> 87	Yrs.	Months Days	Hours Min.	07/17/1	917	Virg	ntrv)
	p		Usual Residence of Decedent								
	anylar show	L.	10a. State 10b. County	10c. City, Tow						1	Od. Inside City Limits
	Ba-f	cto	Maryland Baltimore	Catons	ville			· · · · · · · · · · · · · · · · · · ·			1 Yes 2 No
	with th		10e. Street and Number			10f. Zip Code			10g. Citi	izen of What Cour	ntry?
	death with the Maryland ms 23a or 28a-f show rmust be notified at	erai	352 Greenlow Road	Man Department Francis III C	10.14	21228				ted State	
_	Item Item	Funerai Directo	11. Marital Status 12.  1 □ Never Married 2 □ Married	Was Decedent Ever in U.S. Armed Forces? 1 Mayes 2 □ No	13. Wa	es, specify Cubar	spanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No- Rican, etc.)		<ol> <li>Race - Americ Black, White,</li> </ol>	
Š	owihin 72 hours after death with the Marylan jiene. rithan "naturet", or Items 23a or 28a-f show the Medical Examiner must be notitied at	by	3 Widowed 4 □ Divorced	If Yes, Give Year or Dates: WWII	1 [	Yes 2 No	Specify:			Specify: Whit	t-0
2-0030	72 hor	ompieted	15. Decedent's Educati	on 16a	. Decede	nt's Usual Occupa	tion		16b. Ki	ind of Business/In	
Ž	within 7 iene. • than "r	pje	(Specify only highest grade of Elementary/Secondary (0-12)	College (1-4or 5+)	life. DC	na or work done d NOT use retired)	uring most of work	ing			
V	filed wi Hygien other th	Col	12	Lal	b Tec	chnician			Bri	icking	
alla	be filed tal Hygid d other event, I	Be	17. Father's Name (First, Middle, Last)				18. Mother's Name	e (First, Middle,	Maiden	Sumame)	
<u>8</u>	ould Men arke	မ	Irving Jett Bryant				Julia Ca				
Mar	2 sh and Is m		19a. Informant's Name/Relationship (Type,				nd Number or Run				
e,	1 and 1 ealth sm 27 ther t		James Bryant - Son  20a. Method of Disposition			ion (Name of	Road Cat	consvill		Mary Land	
ĕ	ages or of		1 M Burial 2 ☐ Cremation 3 ☐ Rem	oval from State cemete	ry, crema	tory or other place	9)			101	
aitimor	it. Partmer		* 4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service Ligensée	Woodlar		emetery		/2005	Balt	imore, N	Maryland
מ	permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: if item 27 is marked othe eny injury or other traumatic event, 2008.		* Kathleen a. W.	abel CFSP, CP	C Day	Name and Address 71d J. W. 1 Edmond	ber Fune Son Aven	ral Hom	es l	e. Marvl	and 21229
	100		23a. Part1. Enter the disease, or complicate shock, or heart failure. List only one of	ons that caused the death. Do ause on each line.	not enter	the mode of dying	, such as cardiac	or respiratory ar	rest,	ATERIA DE LA CONTRA	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Motor states	Lu	ing (	once				Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequence	of):	- O					
	xammor	e	Sequentially list conditions, b. =	Due to forms a consequence	-A.						
	ted sit	nine	Sequentially list conditions, if any, leading to immediate causs. Ents Underlying Cause (Disease or injury	Due to (or as a consequence	Ot):						
	ticate be executed j physician and is the burial-transit	Examin	that initiated events c resulting in death) Last	Due to (or as a consequence	of):						
08/PU	siciar siciar	icai									
Q		ed							- 11		•
X Q Q	death certit ie attending ed for use as	ian/M	IF FEMALE: 23b. Was decedent pregnant	If yes, outcome of pregnancy	ء ت	Lieu Carte				23d. Date of delive	ery
	0 0 0	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown		ctopic pregnancy Other <i>(specify)</i>				Month	Day Year
7 5	law requires that the de as been signed by the a 2 should be detached t	Physicia	9 ☐ Unknown								
	es tha	by F	Part II. Other significant conditions contrib	uting to death but not resulting i	in the und	erlying cause give	n in Part I.	23e. Did to	bacco u	ise contribute to the	ne cause of death?
ecords,	w require been si should l							1 U Y	es 2	□No 3 Prob	ably 4 Dunknown
ပို	law i las be	ompieted						24a. Was autop		24b. Were auto	psy findings available mpletion of cause of
=	The law	Con						perfor 1 ☐ Yes	med? 2 No	death?	
Vital H	ysician: This certificate	Be	25. Was case referred to medical examiner?	pitals		O++-	26. Place of Deat			-	
o	Phys this al dir	-To	1 195 2 190	1 Inpatient 2 ENVO	utpatient Time of	3 DOA Cure	4 Nursing Ho				y)
	Attending Physician: or death. ector: After this certific. by the funeral director.	tion	1 Natural 5 Pending		Injury	Work	at ? ′es 2 □ No	28d. Describe h	iow injur	y occurred	
DIVISION	deat deat ctor: y the	fica	3 Suicide 6 Could not be	28e. Place of Injury - At home, fa	arm stree		63 2 110	28f. Location /S	Street an	d Number or Rura	Il Route Number
2	or Attendir after death. Director: Af d in by the fur	ertification:	4 Homicide determined 4	building, etc. (Specify)		i, idolory, offico		City or Tow			a riodio riambor,
	ospite hours neral / fillec	0	29a. Certifier 1 Certifying Physici	an: To the best of my knowledge	e, death o	occurred at the time	e, date and place,	and due to the	cause(s)	and manner as s	lated.
	To the Hospital or Atti within 24 hours after de To the Funeral Direct completely filled in by t	edicai	(Check only 2 Medical Exeminer one)	On the basis of examination ar and manner stated.	nd/or inve	stigation, in my op	inion, death occur	red at the time, o	date and	place, and due to	the cause(s)
	To ti To ti comp	Ž	29b. Signature and title of certifier	- 2		29c. License				e signed (Month,	
			The NOK	wen 2		D.	5445	1	A	pn.1 26	, 2003
	9+1		30. Name and address of person who comp	leted cause of death (Item 28a)	(Typa) Pr	int) Rolds.	de100 (	strice	114	ND 211	2005
:-	Sta Registr		31. Date filed (Month, Day, Year)	32 Registrar's Signature	-	<i>N</i> .					
	. negisti	e II	APR 2 7 2005	Blown &	Asses						

		1 - Stata Amend Item 1&	State of Maryland / <b>Unpend Item 23a</b>	Department of I	Health and Me 8 <b>43</b> a57-5-05	tas	ene2005	1424
		Decedent's Name (First, Middle, Last,				2. Date of Death		3. Time of Death
Physici /Medi	cal	TASHEANN		BURLE		April 23		09:20 p.
Examir	ner	4a. Facility Name (If not institution, give			or Location of Death		4c. County of Death	
Funeral		5700 Hamilton Aven 5. Social Security Number 6. Sec			If Under 24 Hrs.	8. Date of Birth	Baltimore 9. Bidth	County place (State of Forei
Director		219-94-0996 10	M 25 25	Yrs. Months Days	Hours Min.	Month, Day, Y	ear) Col	RVLAND
pug *		Usual Residence of Decedent  10a, State 10b, County	10c City To	own or Location				-/
Aarylan f ehow	ō	2	THORE		- ^ ^ ! =			10d. Inside City Limit 1 ☐ Yes 2 🔭N
tha Mi 28a-f	rect	10e. Steet and Number	MORE	10f. Zin Code	EDALL	100	. Citizen of What Cou	
23s or	0	5700 HAMI	LTON AVENU	F	21237		USA	
er death with the Maryla Items 23a or 28a-f ehov	Funeral Director		12. Was Decedent Ever in U.S. Armed Forces?		Hispanic Origin? (Spectan, Mexican, Puerto R	ify Yes or No-	14. Race - Amer	ican Indian,
or it	by Fu	1 Never Married 2 Married	1 ☐ Yes 2 ☐ No If Yes, Give	1 ☐ Yes 2 💆 No		ican, etc.)	Black, White	
filed within 72 hours after death with the Maryland Hygiene. Hygiene than "natural", or Items 23e or 28e-f ehow ont, the Medical Erer, it we mant be notified and.		3 Widowed 4 Divorced  15. Decedent's Edu	Year or Dates:	Sa. Decedent's Usual Occup			101	ACK
n na	Completed	(Specify only highest grad	e completed)	(Give kind of work done life. DO NOT use retire	during most of working	7	b. Kind of Business/Ir	ndustry
d within 72 hours atl giene. ar than "natural, or	E	11 ++ GRADE	College (1-4or 5+)	STUDE	NT	10	GED PROG	RAM
ba filed stal Hygi of other event, t	Be (	17. Father's Name (First, Middle, Last)	,		18. Mother's Name			
should I	ို	TITUS	BURL	EY	JOCEL			TNSON
C a s s		19a. Informant's Name/Relationship (Ty		9b. Vailing Address (Street				
1 and Health Health tem 27		NORMA JEAN BUR 20a. Method of Disposition	TON(GRANDMOTHEL) 20b. Place	5700 HAM	L TON AVE	Kasel	C Location - City or T	2/23/
Pages nent of I int: If its		1 Burial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify)	emoval from State	iory, crematory or other pla	1			
글 그림픽등		21. Signature of Funeral Service Licens	98 ( )	ZION CEME: 22. Name and Addre	ess of Facility	3-00 Z	ANSDOWN	E, MD.
Depa impo		Weetuch 1	1. William	27955	ess of Facility BROWN FULTON	AVE. B	AITO MA	12 10110
		23a. Part1. Enter the disease, or complished, or heart failure. List only of	cations that caused the death. D	o not enter the mode of dyi	ng, such as cardiac or	respiratory arrest	,	Approximate Interval Between
Physician		Immediate Cause (Final disease or condition	Diabetes Ketoa	cidosis				Onset and Death
/Medical Examiner		resulting in death)	Due to (or as a consequence	e of):				
	Ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequenc	e off:				
utad d ansit	Examiner	cause. Enter Underlying Cause (Discass or Figury that initiated events						
be executed be executed ician and burial-transit		resulting in death) Last	Due to (or as a consequence	e of):				
cate be executed physician and the burial-transit	dical		J					
	/Mec	IF FEMALE:	30. If you subsemp of pro-page.					
eath certific attending p	clan	in the past 12 months?	3c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death	th 3 Ectopic pregnance 5 Other (specify)	у		23d. Date of deliv Month	ery Day Year
that the de ed by the detached	yslo	1 ☐ Yes 2 ☐ No 9 X Unknown	9 Unknown	3 □ Other (specify) _		- 9000		
Attending Physician: The law requires that the death certificates that the death certificates actor: After this certificate has been signed by the attending by the funeral director, page 2 should be detached for use as	by Physician/Me	Part II. Other significant conditions con	tributing to death but not resulting	in the underlying cause giv	ven in Part I.	23e. Did tobac	cco use contribute to t	he cause of death?
w require						1 ☐ Yes	2 No 3 Pro	bably 4 Kunknow
e law re has be	Completed					24a. Was an autopsy	24b. Were auto	opsy findings available empletion of cause of
The The sate has page	Con					performe	d?   death?	2□ No
ysician: This certificate	Be	25. Was case referred to medical examiner?	lannital	0.1	26. Place of Death (	Check only one)		
OVISION ON VILLAI MECONDS, I or Attending Physician: The law requires talter death.  Director: After this certificate has been signed in by the funeral director, page 2 should be	. To	1 X Yes 2 No  27. Magner of Death		Sulpatient 3 DOA			e 6 X Other (Special	y At scene
ding Pt. th. After th	tlon	1 Natural 5 □ Pending 2 Naccident investigation	(Month, Day Year)	Injury Wor	rk? ]Yes 2 □ No	d. Describe how	injury occurred	
Attendr deatl	ertification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At home,			f. Location (Stree	et and Number or Rura	al Route Number,
s afte	Cert	4   Homicide	building, etc. (Specify)			City or Town, S	State)	
To the Hospital or Attenwithin 24 hours after death To the Funeral Director: completely filled in by the	edical	29a. Certifier 1 Certifying Physical Chack only one) 1 Medical Examination	sician: To the best of my knowled ner: On the basis of examination a and manner stated.	ge, death occurred at the til and/or investigation, in my o	me, date and place, an opinion, death occurred	d due to the caus I at the time, date	se(s) and manner as s and place, and due to	tated. o the cause(s)
To th Within To th	Me	29b. Signature and title of certifier		29c. Licens	se number	29d.	. Date signed (Month,	Day, Year)
N. 8		I'my hi,	m.D	OCM	ſΕ	Ap	oril 24, 20	005
18,00m		30. Name and address of person who co	mpleted cause of death (Item 23a	(Type, Print) 111 F	Penn Street		more, Mary	
Sta	ite		- 49	30 A N	R			
Regist		31. Date filed (Month, Day, Year)	7 200 Jane	It foods	g.			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** Helen E. Baker April 25, 2005 10:00 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 11-26-1919 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 M 2 X F Yrs. Director 577-20-7095 85 Washington, DC Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 27 is marked other than "natural", or itams 23a or 28a-1 show traumatic event, the Medical Exacts at insist to notified at 1 ☐ Yes 2 No Director Maryland Anne Arundel Davidsonville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3850 Birdsville Rd. 21035 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ZNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 11th Homemaker **Home** permit. Pages 1 and 2 should be file Department of Health and Menial Hy Important: if Item 27 is marked oth any injury or other traumatic event <u>ance.</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be James Lanham Della Page 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3850 Birdsville Rd., Davidsonville, MD 21035 Jack Baker/ Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State Lakemont Cemetery 4-28-05 Davidsonville, MD \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, ND 21037 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 10 DAYS **Physician** CONGESTIVE HEART disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the death certificate be executed use as the burial-transi Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy 1 Live birth 2 ☐ Fetal death tor Month Year 4 Pregnant at time of death 5 Other (specify) P.0. detached þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Be Completed by pe BILATER AL RENAL ARTERY STENISIS 19 Yes 2 TNO 3 Probably 4 Unknown page 2 should HYPERTENSION 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No FAILURE RENAL certificate 1 Yes 2 NO 25. Was case referred to medical examiner? tuneral director, 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 🖫 1 ☐Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner eath 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 1 Matural 5 Pending death. 1 ☐ Yes 2 ☐ No To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely tilled in by the to 2 Accident investigation 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of gertifier MOMPH 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SUITEHOO 116 DEFENSE HWY MARY CLANCE

State Registrar

APR 2 7 2005

31. Date filed (Month, Day, Year)

32. Registrar's Signature

ORIGINAL

21401

			For State Registrar		Maryland		artment of tificate of			Reg. No.		14247
	Physicia /Medic		Decedent's Name (First, Middle Louis Blondhe	eim					APr	1 23	2005	3. Time of Death
	Examin	er	4a. Facility Name (If not institution  Franklin Sc  5. Social Security Number	puare Hos	or) Dital Age (In yrs. las	st birthday)	4b. City, Town,	edale If Under 24		V	Soutir Boutir	nore
	Funeral Director		213-20-6501 Usual Residence of Decedent	1 <b>∑</b> M 2□F	79	Yrs.	Months Day	s Hours	Min. (Mon	of Birth oth, Day, Year) 06/1925		place (State or Foreign ntry) ryland
	death with the Maryland ms 23e or 28e-f show r must be notified at	5	10a. State 10b. County			Town or Lo						10d. Inside City Limits 1 ☐ Yes 2X No
	ith the M or 28e-f	Funeral Director	MD Balt  10e. Street and Number	imore	KI	ngsvi	10f. Zip Code	_		10g. Cit	tizen of What Cou	
	s 23e	rai	7728 Chapman			1	2108				.S.A.	
415 5-0036	al', or Ite	by	11. Marital Status  1 □ Never Married 2 □ Mai  3 □ Widowed 4 □ Divorcei		ent Everin U.S. es:? □ No WW I es:Korean (	I !	Was Decedent of f Yes, specify Cu 1 ☐ Yes 2 🎇 N		17 (Specify Yes Puerto Rican, e	tc.)	14. Race - Ameri Black, White Specify: Wh	
21215-0	permit. Pages 1 and 2 should be filed within 72 hc Department of Health and Mental Hygiene. Imprements It item 27 is marked other then 'natur any injury or other treumatic event, It a Medical Once.	Completed	(Specify only higher Elementary/Secondary (0-12)	nt's Education st grade completed)  College (1-4		(Give	dent's Usual Occ kind of work don DO NOT use reti	e durina most o	f working		ind of Business/Ir	,
1 0	filed v Hygie other t	Be Co	12 17. Father's Name (First, Middle	Last)		Desi	gn & Tes		Name (First, A		tin Mari Sumame)	etta
ond Heim, L	s 1 and 2 should be filed within the all and Mantal Hygiene if the ma 27 is marked other them other treumatic event, I. A. M.	To B	John Blondhei						a (Unkn			
\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	nd 2 sh lith and 27 is m		19a. Informant's Name/Relation Peggy L. Blot		.)		_				or Town, State, Zi aryland	
He g	es 1 ar of Hea f item		20a. Method of Disposition 1    Burial 2 □ Cremation		20b. Pla	ce of Dispo	sition (Name of natory or other p		Date		ocation - City or T	
To in	permit. Page Department of Importent: If any injury of		*4 □Donation 5 □ Other ( 21. Signature of Funeral Service	Specify)								Maryland
Jond Heim	Depa Impo any ii		Matter 18	an Char	exi	1	1750 Bel	air Roa	ıd - Kir	ngsville	Funeral e, Maryl	Home, P.A. and 21087
9	esconduction.		23a. Part1. Enter the disease, o shock, or heart failure. Lis Immediate Cause (Final	t only one cause on eac	h line.	A		ying, such as ca	rdiac or respira	itory arrest,		Approximate Interval Between Onset and Death
	Physician /Medical Examiner	Ď.	disease or condition resulting in death)	a. Due to (or	as a conseque		ancer					
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. — Due to (or	as a conseque	nce of):						
(3	cate be executed bhysician and the burial-transit	Examiner	cause (Disease or injury that initiated events resulting in death) Last	cDue to (or	as a conseque	ence of):						
8760	cate be e			d							-	
Box 6	attending I	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	4□Pregnar	n 2 ∏ Fetal d it at time of dea	leath 3□	Ectopic pregnar Other (specify)				23d. Date of deliv Month	rery Day Year
م 0	w requires that the d	d by Phys	9 ☐ Unknown  Part II. Other significant condit	9□ Unknow		ing in the u	nderlying cause (	given in Part I.	236		use contribute to t	the cause of death?
Division of Vital Records	ysician: The law req is certificate has been director, page 2 shou	Completed								. Was an autopsy performed?	prior to co	opsy findings available ompletion of cause of
<u> </u>	i <b>cian</b> : Th certificate rector, pag	Be	25. Was case referred to medic examiner?	Hospital:				Whor	f Death (Check			
of	ding Phys h. After this funeral di	on: To	1 ☐ Yes 2 ▼ No  27. Magner of Death 1 ▼ Natural 5 ☐ Pend	28a. Date of		R/Outpatier 28b. Time of Injury	f 28c. In	jury at fork?	28d. Des	Residence scribe how inju	6 □Other (Speci ry occurred	fty)
Divisio	after death. Director: A	Certification:	3 Suicide 6 Could	I not be mined 28e. Place of building	f Injury - At hom s, etc. (Specify)	ne, farm, str	M 1	∏Yes 2 ∏No e	28f. Loca	ation (Street ar or Town, State	nd Number or Rur a)	al Route Number,
	To the Hospitel or At within 24 hours after of To the Funerel Direct completely filled in by	edical C	29a. Certifier Certify (Check only one)	ing Physician: To the bit Examiner: On the bas and manne	is of examination	ledge, death on and/or in	h occurred at the vestigation, in my	time, date and propinion, death	place, and due occurred at the	to the cause(s	) and manner as a d place, and due t	stated. to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certific	er P.			Da	nse number	53	Apr.	te signed (Month,	2005
_	12+1		30. Name and address of perso	who completed cause	of death (Item 2	_	Print)	Saware	Orive	Pallin	Mare MI	0, 21237
	Sta Regist		31. Date filed (Month, Day, Yea APR 2	7 2005	gistrar's Signatu		and 5	A	pi, vo	·	1101	a big
- 1	OHMH 17 Bev 1/2		nin Z	\$ 2003 U	We SU	M	-					

# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

				State of Ma	ryiand / Dep <i>Ce</i>	ertificat			- 1	giene Reg. No. 🤈 🗥	OE	11010
	Physici	an	1. Decedent's Name (First, Middle, La	st)		-			2. Date of Dea	ath Day	Year	3. Time of Death
-	Physici /Medi		SUE	JEAN	BLACK				April	20, 20	005	1:15 A.M.
j	Examir		4a. Facility Name (If not institution, giv				4		Location of Death	,		
			Alice Byrd Tawes			. Killada	. 1 Vans	Crisfie			erset	
	Funeral Director		5. Social Security Number 6. S 282-26-5440	DM OFF	(In yrs. last birthday 75 Yrs.	Months		If Under 24 Hrs Hours Min	8. Date of Birt (Month, Day October 5	y, Year)		ace (State or Foreign iry) 1881ppi
	and and		10a. State 10b. County		10c. City, Town or L	ocation					10	Od. Inside City Limits
	Many If sh	ţ	Maryland Somer	set	Crist	field						1√2 Yes 2 □ No
	r 28s	<u>se</u>	10e. Street and Number			10f. Zip	Code			10g. Citizen of \	What Count	try?
	th wit	aiD	22 W. Main St.				2181	.7		U.	S.A.	
020	s 1 and 2 should be filed within 72 hours after death with the Maryland if Heelth and Mental Hygiene. them 27 is marked other than "natural", or items 23a or 28e-f show other traumatic event, the Medical Exercities in the Institled at	by Funeral Director	11. Marital Status  1 □ Never Married 2K∑ Married  3 □ Widowed 4 □ Divorced	12. Was Decedent Ev Armed Forces? 1  Yes 2  No If Yes, Give Year or Dates:	ver in U,S. 13.	Was Deced If Yes, special 1 Yes			Specify Yes or No- to Rican, etc.)	14. Rad Blad Specify	e - America ck, White, e	etc.
Maryland 21215-0020	within 72 ho iene. than "natur the Medical I	Completed by	15. Decedent's Ec (Specify only highest gre Elementary/Secondary (0-12)	fucation de completed) College (1-4or 5+	(Give	edent's Usua e kind of wo DO NOT us	al Occupa rk done d se retired	ation during most of wo	rking	16b. Kind of Bi	usiness/Ind	ustry
12	ygien ygien her th	Sol	11		Home	emaker	:			At Home		
anc	should be filed vand Mental Hygies marked other turnatic event, It	Be	17. Father's Name <i>(First, Middle, Last)</i> Edward Martin						me <i>(First, Middl</i> e, ie Johnse		10)	
Z	2 should and Me is mark aumatic	은	19a. Informant's Name/Relationship (	Type Print)	19h Mail	ina Address	(Street		ural Route Numbe		State Zin	Code)
	nd 2 solith ar		Elmer J. Black (H						risfield		1817	
re,	if Health item 27 I		20a. Method of Disposition		20b. Place of Disp cemetery, cre	osition (Nar	ne of		Date	20c. Location -		vn, State
Ē	Page nent c int: If		1 XBurial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		Sunnyridge			*	4/25/05	Crisf	ield,	MD
Baltimore,	permit. Pages 1 and Department of Heelth Important: If item 27 any Injury or other tr once.		21. Signature of Funeral Service Licen	Tadely,	31	cadsha	& WE		neral Ho		1015	
	_			shaw, Jr	he death. Do not en	ter the mod	Malr le of dyin	1 St Ci g, such as cardia	risfield c or respiratory ar	, MD 2. rest,	1817	Approximate Interval Between
23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Physician /Medical Examiner  Immediate Cause (Final disease or condition resulting in death)  a												Interval Between Onset and Death
		Je.		D	ue to (or as a conse	quence of):					1	
<b>'</b>	Attending Physician: The law requires that the death certificate be executed at death.  ector: Atter this certificate hes been signed by the ettending physician and by the funeral director, page 2 should be deteched for use as the buriel-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b	eando a sa to) ut eu	quence of).					1	
68760,	ficate be physicials the bu	Physician/Medical	Cause (Disease or injury that initiated events resulting in death) Last	C	ue to (or as a conse	quence of):			- In (e site			
Box (	onding use a	Ž	•	d								
Ω.	death cer e ettendir ed for use	sicia	Part II. Other significent conditions of	ontributing to death but	not resulting in the u	ınderlyina c	ause give	en in Part I.	23b. Did to	obacco use co	ntribute to	the cause of deeth?
P.0	at the de d by the e eteched	Phy				,	<b>3</b>		1 🗆 1			ably 4 Unknown
S,	res that signed t s be det	ρ							_		I	
Division of Vital Records,	e law require hes been sig ge 2 should b	Completed							24a. Was e perfor	en autopsy med?	avai	re autopsy findings flable prior to spletion of cause eeth?
Ξ Ξ	The la	S							1□Y	es 2 No	10	Yes 2□ No
Vita	ysician: This certificate	Be	25. Was case referred to medical examiner?	Heeritet.	***		011		ath (Check only or			
of	Physi this o	7.	1 ☐ Yes 2)X No 27. Manuer of Death	Hospital: 1 ☐ Inpatient			-	4 Latinursing F	lome 5 ☐ Resid			
sion	ending I eath. or: After the funer	Certification:	1 Naturel 5 Pending investigation 3 Suicide 6 Could not be			М	_	at ? ∕es 2 □ No	28d. Describe h	ow injury occurr	ea 	
Dİ	he Hospital or Attending Ph in 24 hours after death. he Funeral Director: After thi pletely filled in by the funeral		4 Homicide determined	28e. Place of Injun building, etc.	y - At home, farm, st (Specify)	reet, factory	r, office		28f. Location (S City or Tow		er or Rural	Route Number,
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	edicai	29a. Certifier Check only one) Certifying Physics Medical Example 2 Medical Example 2	ysician: To the best of niner: On the basis of e and manner state	xamination and/or in	h occurred a vestigation,	at the tim in my op	e, date and place inion, death occu	e, and due to the corred at the time, co	ause(s) and ma late and place, a	nner as sta and due to	ited. the cause(s)
	To the within 2 To the comple	Σ	29b. Signature and title of certifier		2	290	. License		2	29d. Date signed	1	•
	Λ		• (1)	1 + 0	7)	D 48098 4/21/2005						
	クク		30. Name and address of person who									
			Vijay Karumbunath	an, M.D. –  32. Pagistrar	201 Hall	Highw	ay -	- Crisfi	eld, MD	21817		
	Sta Registr		APR 2 7 2	חחה	- Signaturo	A 700 A 7	Ps					

DHMH 16 Rev 6/95

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) 3. Time of Death Physician April 21, 2005 Year William Kenneth Bennett, IV 12:15 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 411 Lakeview Ave. Edgewater Anne Arundel If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 5. Social Security Number 8. Date of Birth 12-21-1954 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 1**⊠**M 2□F Maryland 219-68-2629 50 Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County or 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heatih and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-1 ehow any injury or other traumatic event. The Modical Exaction or other traumatic event. 1 ☐ Yes 2 ☑ No Director Maryland Anne Arundel Edgewater 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 411 Lakeview Ave. 21037 USA Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 1 Never Married 2X Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: White Be Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Paint Store years Manager 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) William K. Bennett, III Betty Jean Bates 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donna L. Bennett/ Wife 411 Lakeview Ave., Edgewater, MD 21037 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 ☐ Cremation 3 ☐ Removal from State 4-25-05 Davidsonville, MD Lakemont Cemetery ' 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Solvice Vicensee 22. Name and Address of Facility George P. Kalas Funeral Home Illmto 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** STVOKP reels /Medical Due to (or as a consequence of): sophageal cancer **Examiner** months Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine and I-transit The law requires that the deeth certificate be executed Due to (or as a consequence of): burial-Box 68760. physician Physician/Medical the attending for use as 23c. If yes, outcome of pregnancy 1□Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Year Month 4☐Pregnant at time of death 5 Other (specify) signed by the aid be detached for 1 ☐ Yes 2 ☐ No Records, P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 2 No certificate 1 Yes Division of Vital To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 4 Nursing Home 5 Residence 6 □Other (Specify) 2 3 DOA this 28a. Date of Injury (Month, Day Year) After the 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Injury 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No death. investigation filled in by the within 24 hours after deatl To the Funeral Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified 0005 1301 9 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Moad #300 Bestrate 900 31. Date filed (Month PR gistrar's Signature State 2005

DHMH 17 Rev 1/2001

Registrar

			1 - For State Registrar	State of Ma	aryland / Depa <i>Cei</i>	artment of I			jiene	5 11-250
	Physici		1. Decedent's Name (First, Middle, Last)  Sybil L. Sylvinian Sylvi		Boyd			2. Date of Dea Month	ith _	ear 7p.m. M
	/Medic Examin		4a. Facility Name (If not institution, give s 1012 Vine Street	treet and number)	БОУС	4b. City, Town, 6	or Location of Death		4c. County of I	Death
	Funeral Director		5. Social Security Number 6. Sex 219-40-7958	M 2 <b>√</b> F 7. Ag	e (In yrs. last birthday) 59 Yrs.	If Under 1 Year Months Days		8. Date of Birtl (Month, Day 3 29	1945 9.	Birthplace (State or Foreign Country) Md
	e Maryland a-f show	ctor	10a. State 10b. County N/A		10c. City, Town or Lo Baltimor					10d. Inside City Limits 1 X Yes 2 □ No
	th with the 23a or 28 ust be no	al Director	10e. Street and Number 1012 Vine Street			10f. Zip Code	21223		10g. Citizen of Wha USA	it Country?
9000	ges 1 and 2 should be filed within 72 hours after death with the Maryland tof Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, it is Medical Exarcitation to intellised at	d by Funeral	11. Marital Status  1X Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	2. Was Oecedent Armed Forces? 1 Yes 2 1 If Yes, Give Year or Dates:	No I	Was Decedent of I f Yes, specify Cub 1 ☐ Yes 2☐XNo	Hispanic Origin? (Sp ban, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	Black, \	American Indian, White, etc. Black
Maryland 21215-0036	filed within 72 h Hygiene. Other then "natuent, II e Mayle:	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) 10th grade	College (1-4or 5	(Give	dent's Usual Occu kind of work done DO NOT use retire Driver	during most of work		City of Public	Balto
land	should be fil and Mental H s marked ott umatic even	To Be	17. Father's Name (First, Middle, Last)  Columbus James					e ( <i>First, Middl</i> e, Gray Mod	Maiden Sumame) lica	
Mary	id 2 should be lith and Mental 17 is marked ( traumatic ev		19a. Informant's Name/Relationship (Type Sameka Watford — I				tand Number or Rur treet Ba	al Route Numbe	r, City or Town, Sta	te, Zip Code)
Baltimore,	ages 1 and 2 ant of Health it: If item 27 I y or other tre		20a. Method of Disposition 1   Burial 2 □ Cremation 3 □ Ri 4 □ Donation 5 □ Other (Specify)	emoval from State	20b. Place of Dispo	sition (Name of natory or other pla	ice)	Date	20c. Location - City	
Baltin	permit. Pages 1 Department of H Important: If ite any injury or ot		21. Signature of Ferroral Service Licente		0 22	. Name and Addre		ARCH F/H		21215
	Physician /Medical Examiner	er.	23a. Part 1. Enter the disease, or complishock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any leading to immediate	Due to (or as	the death. Do not ent			or respiratory ar		Approximate Interval Between Onset and Death
68760,	the death certificate be executed y the attending physician and tched for use as the burial-transit	edicai Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as	a consequence of):					
.O. Box		Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 25 No 9 □ Unknown	3c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death 3	Ectopic pregnanc Other (specify)	у		23d. Date of Month	f delivery Day Year
ords, P	The law requires that ite has been signed b age 2 should be deta	leted by P	Part II. Other significant conditions con	tributing to death b	ut not resulting in the u	nderlying cause gr	ven in Part I.	10.0	_	ite to the cause of death?
Vital Records,		Comple						24a. Was a autop perfor 1 Yes	sy prior med? deat	re autopsy findings available r to completion of cause of th? Yes 2 \sum No
of	Attending Physician: Tride ath. ector: After this certifical by the funeral director, p	ation; To Be	25. Was case referred to medical examiner?  1  Yes  No H  27. Manner of Beath  1  Natural 5  Pending 2  Accident investigation	ospital: 1 Inpatie 28a. Date of Inju (Month, Da		28c. Inju	ry at	me Resid	ne) ence 6 □Other (. ow injury occurred	Specify)
Division	al or Attend s after death il Director: ,	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inj building, et	ury · At home, farm, str c. (Specify)	eet, factory, office		28f. Location (S City or Tow	treet and Number o n, State)	or Rural Route Number,
	To the Hespital or within 24 hours after To the Feneral Directorpletely filled in b	Medical (	29a. Certifier Check only 2 Medicel Examinone)	icien: To the best er: On the basis o and manner st	of my knowledge, deatl f examination and/or in ated.	n occurred at the ti	ime, date and place, opinion, death occur	and due to the cred at the time, c	ause(s) and manne ate and place, and	or as stated. due to the cause(s)
	To the Company	7	29b. Signature and title of certifier	~ Ne	N,	29c. Licen	se number	+1 1	Pod. Date signed (A	10nth, Day, Year
6	211		30. Name and address of person who co	mpleted cause of o	leath (Item 23a) (Type,	Print) 30	0) S.	etta	vove,	KST1225
	Sta Registi		31. Date filed (Month, Dáy, Year)  APR 2 7 2005	32. Registr	ar's Signature	8				

State of Maryland / Department of Health and Mental Hygiene) Registrar AMEND ITEM #4b, 10c&19b PER ME POSE LE 1277 POSUM 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Vernon Α. Bethea 16:04 M April 21, 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Adeliphi ADELPHI Prince Georges 10414 Rutland Place 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)

July 16, 34 | North Carolin 5. Social Security Number **Funeral** Days Months Hours 1 M 2 □ F 245-60-9854 70 Director Yrs. Usual Residence of Decedent with the Maryland 10a State 10c. City, Town or Location 10d. Inside City Limits ?7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Modical Examination of the notified at Prince Georges Adeliphi Md **ADELPHI** 1 XYes 2 No Director 10g. Citizen of What Country? U.S.A. 10e. Street and Number 10f. Zip Code 20783 10414 Rutland Place e filed withIn 72 hours after death all Hygiene.
other than "natural", or items 23. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Xes 2 No If Yes, Give Year or Dates: 53-55 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify:Black 1 ☐ Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) D.C. Government College (1-4or 5+) Elementary/Secondary (0-12) Teacher 5+ (Phd) 17. Father's Name (First, Middle, Last)
Braxton Bethea 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be fit tment of Health and Mental H tant: If item 27 is marked ot Vietta Manning 19b. Mailing Address (Street and Number or Rural Route Number Grant Found Place Adeliphi Md. 20 19a. Informant's Name/Relationship (Type, Print) Rachel Bethea <del>iphi</del> Md.20783 other 20b. Place of Disposition (Name of cometery, crematory or other place) 20a Method of Disposition April 29, 20c. Location - City or Town, State permit. Pages Department of Important: If it any injury or o 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) Adelphi, Md. George Washington 05 21. Signature of Funeral Service Licensee Home 1313 6th St.N.W. Washington, D.C. 20001 Robinson Funeral 23a. Part Enter the disease, or complications that caused the shock, or heert failure. List only one cause on each line. th. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Atherosclerotic Cardiovascular Disease /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Due to (or as a consequence of): Examiner cause. Enter Underlying Cause (Disease or injury To the Hospital or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physicien and anding physicien and use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3 □ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🔀 No Month Year Day 4☐ Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 QUnknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? death? 1X Yes 2 No 2 \ No : After this certifical tuneral director. Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) SCENE 1X Yes 2 □ No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? 1X Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of or 29c. License number 29d. Date signed (Month, Day, Year) RIPPLE Su OCME April 22, 2005 4 who completed cause of death (Item 23a) (Type, Print) 30. Name and Rubi Ana 111 Penn Street Baltimore, Maryland 21201 Md 33. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar APR 2 7 2005

			4 Chata	tate of Maryla	and / Depa	artment of H	lealth and	d Mental Hygi		11.252	
I	Division		1. Decedent's Name (First, Middle, Last)  2. Date of Death PR 20, 2005 3. Time of Death Month Day Year								
	Physici /Media		James W Bagley				65 29 1948 3:58p M				
7	Examir	er	4a. Facility Name (If not institution, give street and number)			4b. City, Town, or Location of Death			4c. County of Death		
			3504 GREENSPRING 5. Social Security Number 6. Sex		rs. last birthday)	BALTIM If Under 1 Year	IORE	frs. 8. Date of Birth	N/A	dhalaa (Cata a Fasi	
	Funeral Director			2□F 5	6 Yrs.	Months Days		lin. (Month, Day,	rear) _	rthplace (State or Foreign ountry) YLAND	
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Menal Hygiene. Important: If item 27 is marked other than "natural, or items 23a or 28a-f show any injury or other traumatic event, if a Medical Exist. In at train the incilling at ORCs.	ctor	10a. State 10b. County		City, Town or Lo			<u>_</u>		10d. Inside City Limits	
			MD. N/A		BALTIMO	RE				1 XYes 2 □ No	
		Dire	10e. Street and Number			10f. Zip Code		10	g. Cilizen of What C	ountry?	
		ral	3504 GREENSPRING			2121		(0.00)	USA		
		by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	Was Decedent Ever ir Armed Forces? 1 XYes 2 ☐ No If Yes, Give Year or Dates:	l I	Mas Decedent of H f Yes, specify Cuba 1 ☐ Yes 2☐XNo		(Specify Yes or No- erto Rican, etc.)	14. Race - Am Black, Wh Specify:		
		Completed	15. Decedent's Educati	on	16a. Deced	lent's Usual Occup	ation	1	6b. Kind of Business	s/Industry	
		nple	(Specify only highest grade co	College (1-4or 5+)	life. L	kind of work done o DO NOT use retired	during most of ( d)	working			
2			-12-	-0-	SUI	PERVISOR			FOOD		
and		Be	17. Father's Name (First, Middle, Last)					Name (First, Middle, M	aiden Sumame)		
Maryland		T <sub>o</sub>	JAMES BAGLEY  19a. Informant's Name/Relationship (Type,	Print)	19h Mailin	n Address (Street		GRIMES  Rural Route Number,	City or Town State	Zin Cada)	
			ANN BAGLEY (WIFE)	,				LE, MARYLA	-	25 0000)	
Jre,			20a. Melhod of Disposition	20t		sition (Name of natory or other place			Oc. Location - City o	Town, State	
Ē			1 ☑ Burial 2 ☐ Crept ation 3 ☐ Rem '4 ☐ Donation 5 ☑ Other (Specify)	G		FOREST V	1		INGS MILL	S, MARYLAND	
Baltimore,			21. Signature of Funeral Service Licenset	ONATHAN D.				HILLIPS FU	NERAL HOM		
,	Physician /		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Gause (Final disease or condition resulting in death)  Due to (or as a consequence of):								
P.O. Box 68760,	cate be executed physician and physician and sthe burial-transit	d by Physician/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last  b. Cirrhosis of Liver  Due to (or as a consequence of):  c. Due to (or as a consequence of):								
	The law requires that the death certif ate has been signed by the attending page 2 should be detached for use as					Ectopic pregnancy Other (specify)			23d. Date of delivery Month Day Year		
			Part in Other significant continuous continuous to death out not resulting in the underlying cause given in Part I.					_	o the cause of death?		
Vital Records,		Completed	Coronary Artery Diseas.			24a. Was an autopsy perform			245. Were autopsy findings available prior to completion of cause of death?		
tal		a)	Hefa+1+13 C 1 Yes 20No 1 Yes 20No						242 No		
of	S S	0.8	25. Was case referred to medical examiner?  1  Yes 2 No  Hospital: 1 Inpatient 2 ER/Outpatient 3 DoA  Other: 4 Nursing Home 5 Residence 6 Other (Specify)							icify)	
	To the Hospital or Attending Phys within 24 hours after death.  To the Funeral Director. After this completely filled in by the funeral di	ertification: T	27. Manney of Death  1 Chatural  2 Accident  3 Suicide  4 Homicide  28a. Date of Injury (Month, Day Year)  28b. Time of Injury (Month, Day Year)  28b. Time of Injury 2b. Time of Injury 2b. Time of Injury 2b			28c. Injury at Work?  M 1 Yes 2 No					
		O				City or Town, State)			State)		
		Medical	29a. Certifier  (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
	To t To t		29b. Signalure and title of certifier			29c. License		and the state of t	1. Date signed (Mont	h, Day, Year)	
	CX		Jam during			80054990 4			4/22/0	122/2005	
30. Name and address of person who shipleted cause of death (Item 23a) (Type, Print)  390/ 1/10 Ala Wie a Bart 1 more, MD 2/2/18  State Registrar  APR 2 7 2005  Registrar's Signature								- /			
State 31. Date filed (Month, Day, Year)  Registrar APR 2 7 2005											

Malik 05-02		But	ler-Hill Please Type or Print in Black Indelible Ink. Ensure A		-	
RPD			State of Maryland / Department of Health and New State of Maryland / Department of Health and New State of Leasth Registrar		ne 005	14253
	Physici	an	1. Decedent's Name (First, Middle, Last)  Mail K Lastonar Rutler - Hill	2. Date of Death Month April 21	Day Year	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death		4c. County of Death	
00			2578 Edmondson Avenue Baltimore  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year   If Under 24 Hrs.	8. Date of Birth	9. Birt	hplace (State or Foreign
550	Funeral Director		Usual Residence of Decedent	Jan. 14, 3	005 M	aryland
4 6	ours after death with the Maryland reit, or Items 23e or 28e-f show Examinar must be routified at	ctor	Maryland NIA Baltimore			10d. Inside City Limits 1
	with the	Director	10e. Street and Number  10f. Zip Code  21223	10g.	Citizen of What Co	untry?
	ems 23	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Sp. 17 Fys., specify Cuban, Mexican, Puerto	pecify Yes or No- Rican, etc.)	14. Race - Ame Black, White	
36	urs after	by Fu	1 Never Married 2 Married 1 □ Yes 2 No If Yes, Give 1 □ Yes 2 No Specify: 3 □ Widowed 4 □ Divorced Year or Dates:		Specify: P	ack
2-00	72 hours "neturel", dical Ex		15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired)	king 16t	. Kind of Business/	Industry
121	iene. r then	Completed	Elementary/\$econdary (0-12) College/(1-4or 5+)		NA	
Maryland 21215-0036	2 should be filed within 72 hours after and Menial Hygiene. Is marked other then "neture", or Ite marked other, Ite Medical Examine eumatic event, Ite Medical Examina	Be	17. Father's Name (First, Middle, Last)  18. Mother's Nam	e (First, Middle, Mai	den Sumame)	0 -
aryla	d 2 should th and Men 7 is marke treumatic	2	19a. Informant's Name/Relationship (Type, Print) motter 19b. Mailing Address (Street and Number or Ru	ral Route Number, C	ity or Town, State, 2	Zip Code)
,≅			NIS, Candace Butler 2145 Hollins St.	Balta Date 200	. Md. o	11223
Baltimore,	permit. Pages 1 and 2 Department of Health a Importent: If item 27 is any injury or other tre once.		20a. Method of Disposition  1 ★ Burial 2 ☐ Cremation 3 ☐ Removal from State  1 ☐ Donation 5 ☐ Other (Specify)  20b. Place of Disposition (Name of cemetery, crematory or other place)  1 ☐ Donation 5 ☐ Other (Specify)	12005 L	1	wne, Md.
altir	permit. P Departme Importen any injuri		21. Signature of Funeral Service Licensee 22. Name and Adress of Facility	aral Ham	e. P. A	viicjiia.
<u> </u>	9 9 E # 9	11 2	2222 W.North Ave.	Balto M	1.21216	Approximate
	Physician /Medical		23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Asphyxia Due To Overlay  Due to (or as a consequence of):			Interval Between Onset and Death
	Examiner	L	Sequentially list conditions, b. Duta (consequences)			
	secuted and I-transit	xamine	if any, leading to immediate cause. Enter Underlying Cause (disease or injury that initiated events c.			
,0		ш	resulting in death) Last Due to (or as a consequence of):			
3876	icate b physic s the b	edica	d			
P.O. Box 68760	Attending Physicien: The law requires that the death certificate be extragath. r death. ector: After this certificate has been signed by the attending physician a by the funeral director, page 2 should be detached for use as the burial.	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No  23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 5 ☐ Other (specify)		23d. Date of del Month	livery Day Year
P.0	that the death ned by the atter	Phys	9 Unknown  Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobac	cco use contribute to	the cause of death?
rds,	w requires t been signe should be	ed by	<u></u>	1 ☐ Yes	2 <b>X</b> No 3□Pi	robably 4 Unknown
Division of Vital Records,	The law re ate has bee page 2 sho	Completed		24a. Was an autopsy performe	prior to death?	utopsy findings available completion of cause of
Vita	ysicien: The is certificate hadirector, page	Be	examiner? Hospital: Other	ath (Check only one)	es & MOther (See	soife)
of	Jing Phys n. After this funeral di	n: To	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at	28d. Describe how	injury occurred	
sior	death. ctor: Af	catic	2 X Accident investigation 4-21-05 8:31 A M 1 Yes 2 X No	Subject S		
Divi	el or At after of Direct din by	Certification:	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  Scene	Baltimore		edinomison Ave
	To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: Atter th completely filled in by the funeral	ledical (	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place and manner stated.	a, and due to the causured at the time, date	se(s) and manner as a and place, and due	s stated. e to the cause(s)
	To th within To th comp	W	29b. Signature and title of certifier 29c. License number	Åp:	Date signed (Moni ril 22, 2	h Day, Year) 005
			30, Name and address of person who completed cause of death (Item 23a) (Type, Print)			
-			ANA RUBIO, MO 111 Penn Str	eet Balt:	imore, Ma	cyland 21201
	Si Regis	tate trar	31. Date filed (Month, Day, Year)  32. Registar's Signature			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien [ For State Registrar **AMEND ITEM #31 per dvr g842 49121/193**e **pf** Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 0710 AM Edmond 26 live /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Howard County General Hospital Columbia Howard 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1₩ 2□F 003-03-1354 Director AUG. 22, 1920 New Hampshire Usual Residence of Decedent with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show Examiner must be notified at 1 ☐ Yes 2 ☑ No Director MD Howard Elkridge 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7136 Ducketts Lane, Apt. 101 21075 USA naturel, or items 23a Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Army AF 1 ⊠ Yes 2 □ No If Yes, Give Year or Dates 1942-46 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White δ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Letter Carrier U. S. Postal Service 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be and Mental Edmond Chaloux Medora Decoteau 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If item 27 Is Dennis Chaloux - son 6108 Lorie Lane, Elkridge, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State ` 4 ☐ Donation 5 ☐ Other (Specify) Baltimore Wash. Crm. 4/28/2005 Laurel, MD 22. Name and Address of Facility
Gary L. Kaufman Funeral Home @ Meadowridge MP, Inc. 21. Signature of Fun al Service Ucenses 7250 Washington Blvd., Elkridge, MD 21075 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 50,05/5 12hours /Medical Due to (or as a consequence of): **Examiner** cancer - cobo resection Colon Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed physician and is the burial-trans COPP Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performs 24b. Were autopsy findings available prior to completion of cause of death? 2 No 2□ No certificate 1 ☐ Yes 1 Tyes or Attending Physicien: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 ပ 1 Depatient 2 ER/Outpatient 3 DOA After thi 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: Natural
Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Scertifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical

within 24 hours a

State Registrar (Check only one

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2005

Ch

5501

32. Regi**gi**rar's Signature

DHMH 17 Rev 1/2001

0/4

29c. License number

00058

00/15

2104

29d. Date signed (Month, Day, Year)

			For State Registrar	State o	f Maryland /		artment rtificate			and M	•	giene Reg. No	005	11/5000
	•	÷.	Decedent's Name (First, Middle,	Last)							2. Date of De	ath	444	3. Time of Death
	Physici /Medi		Edna Laura (	reech							April 2	21, Day	2005 Year	10:00 AM
):	Examir		4a. Facility Name (If not institution,	give street and nur	nber)				Location	of Death		4c.	County of Deat	h
			47 Ridge Avenue					ewat					Anne Arı	ındel
1	Funeral Director		577-36-6287	5. Sex 1 ☐ M 2 ☐ F	7. Age (In yrs. last b. 81	irthday) Yrs.	If Under Months	Days	If Under Hours	Min.	8. Date of Bird (Month, Da 2-18-2	Year)	Co	nplace (State or Foreign untry) nada
	and		Usuat Residence of Decedent  10a. State 10b. County		10c. City, Tov	wn or Lo	ocation						1	10d. Inside City Limits
	Many -f sho	to	Maryland Anne	Arundel			ewateı	r						1 ☐ Yes 2 ☐ No
	r 28a	irec	10e. Street and Number			73049	10f. Zip					10g. Citiz	zen of What Co	untry?
	23£ c	al D	47 Ridge Ave.				21	1037					USA	
21215-0036	be filed within 72 hours after death with the Maryland tal Hyglene. Id other then "naturel", or Items 23c or 28e-f show event, the Madical Examirer must be mailified at	by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Marrie  3X Widowed 4 □ Divorced	Armed Fo	2 [ <b>X</b> No e	1	Was Decede If Yes, speci 1 Yes 2		spanic Ori n, Mexicar Specify:		ecify Yes or No Rican, etc.)		14. Race - Amer Black, White Specify: V	
2-0	72 ho	eted	15. Decedent's (Specify only highest		16a		dent's Usual kind of work			t of work	ina	16b. Kin	nd of Business/I	ndustry
21	ithin ben "	Completed	Elementary/Secondary (0-12)	College (1	-4or 5+)	life.	DO NOT use	e retired,	uring mos	OI WOIK	ng			
121	iled w dygler ther tl		7th 17. Father's Name (First, Middle, L	251		_Ho	memake	er	10 Moths	da Name	(First, Middle,	Maidan	Home	
Maryland	d d d	o Be	Victor Paradis	231/							Cousine		Sumame)	
ary	s 1 and 2 should if Health and Men Item 27 is marka other treumatic	2	19a. Informant's Name/Relationsh	p (Type, Print)	19	b. Mailir	ng Address	(Street a					Town, State, Z	ip Code)
	s 1 and 2 of Health a Item 27 is		Linda J. Dove/	Daughter	_ 3	4 R	idge <i>1</i>	Ave.	, Edg	rewat	er, MD	2103	37	
altimore,	ges 1 a of He If Item or othe		20a. Method of Disposition 1 □ Burial 2 ☒ Cremation	Pomoval from !	20b. Place o	of Dispo	sition (Nam	e of her place	)		Date	20c. Loc	cation - City or 1	Town, State
Ē	Pages ment of I ent: If Its ury or o		*4 □ Donation 5 □ Other (Sp.		Kala	as C	remat	ory		4-22	-05	Edge	ewater,	MD
Balt	permit. Pag Department Importent: I any injury o		21. Signature of Funeral Septite L	ulu	_		973 Sc			00	_			eral Home ID 21037
	/Medical Examiner	Examiner	shock, or heart failure. List of Immediate Cause (Finat disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	a. Pue to (		of):	for d	Isca	sc j	nabe	We Ci	IA		Interval Between Onset and Death
68760,	ficate be executed physician and s the burial-transit	edical Ex	resulting in death) Last	Due to (	or as a consequence	of):								
.O. Box	The law requires that the death certific tte has been signed by the attending p page 2 should be detached for use as:	Physician/Mo	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes  9 ☐ Unknown	1 ☐ Live bi	come of pregnancy inth 2 Petal death ant at time of death		Ectopic pre Other (spe					2	3d. Date of delik Month	very Day Year
rds, P	w requires that been signed t should be deta	by	Part II. Other significant condition  Neschelel vascula	s contributing to de	10001	1.	nderlying ca		n in Part I.		23e. Did to			the cause of death?
Vital Records,		Completed	dys/pidenia								24a. Was autop perior	sy	24b. Were aut prior to co death? 1 \(\sum \text{Yes}\)	opsy findings available ompletion of cause of
Ζ		o Be	25. Was case referred to medical examiner?	Hospital:				Cthe			Check on o			
of	y Phys er this eral di		1 Yes 2 70 27. Manner of Death	28a. Date o		Time of		c. Injury	at Nu		ne 5 <b>y</b> Resid 28d. Pescribe h		Other (Speci	ify)
ion	Attending Programmer death. Sector: After by the funer.	atlo	1 Natural 5 ☐ Pending 2 ☐ Accident investiga		n, Day Year)	Injury	М	Work 1 □ Y	? es 2 □ l	No ,				
Division	al or Attend s after death of Director: ,	Certification:	3 Suicide 6 Could no 4 Homicide determin	ed 289. Place	of Injury - At home, fang, etc. (Specify)	arm, str	eet, factory,	office			28f. Location (S City or Tow		Number or Rur	ral Route Number,
	To the Hospital or A within 24 hours after To the Funeral Direct completely filled in by	Medical (	29a. Certifier (Check only one)	Physician: To the kaminer: On the ba and mann	best of my knowledg sis of examination ar er stated.	e, death	occurred a restigation, i	t the time	e, date an inion, dea	d place, a	and due to the dead at the time, d	ause(s) a date and p	and manner as a	stated. to the cause(s)
)	To t To t	M	29b. Signature and Little of certifier	1000	g ma		29c.	License	number		2	4/2	signed (Month)	
	V		30. Name and address of person w Charles W. Phel	AC MA	of death (Item 23a)	Туре,	Print)	15.7	Shi	rd 1	ld. Am	Apoli	i wo	2/40/
	Sta Registr	_	31. Date filed (Month, Day, Year)	7 2005 32. R	strar's Signature	-	back	7						

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** APRIL 25, 2005 5:16A Leon Dicks /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Saint Joseph Medical Center Towson Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) **Funeral** Months 1**X** M 2□ F Director 244-42-1886 71 South Carolina Usuel Residence of Decedent with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location 7 le marked other then "natural", or Itama 23a or 28a-f ehow traumatic event, the Medical Examinar must be notified at 1 Yes 2 No Director Baltimore Lutherville 10g. Citizen of What Country? 10e. Street and Numbe 10f. Zip Code 21093 214 Coldbrook Road USA filed within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. 1 X Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced Black. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) 12 Cook 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pagas 1 and 2 should be file Dapartment of Health and Mantal Hy Important: If Itam 27 Is marked oth any linjury or other traumatic event one. 17. Father's Name (First, Middle, Last) Be Mattie Dicks Leon Dicks 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Christine V. Johnny/ Cousin 214 Coldbrook Road Lutherville, MD 21093 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest Veteran 05 - 02 - 05Owings Mills, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Wylie Funeral Home 638 N. Gilmor St. Baltimore, MD 21217 23a. In Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** MONTHS EUKEMIA disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Listable of Irjuly) that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed use as the burial-transi tha attanding physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Dav 4 Pregnant at time of death 5 Other (specify) datachad 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown page 2 should ANEMIA Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 D No 24a. Was an THROAT CANCER cartificata has autopsy 2 P No fillad in by the funeral director, 25. Was case referred to medica examiner? 26. Place of Death (Check only one Hospital: Other: 2 ER/Outpatient 3 DOA Certification: To 1 ☐ Yes 2 No 1 🔲 Inpatient 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Aftar ! 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No s after death. daath 3 🗌 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 0 To the Hospital within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical complataly 29c. License number 29b. Signature D 17695 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DRIVE TOWSON MARYLAND 21204 32. Jegistrar's Signature State Registra

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Year Month **Physician** 4:48 a M Robert Glenn Denton, Sr. April 20 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 700 Cotter Road Glen Burnie Anne Arundel If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □XM 2 □ F 77 Yrs Director 215-22-7290 New York Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits 28e-f show other treumatic event, the Modical Examiner must be natified at Completed by Funeral Director 1 ☐ Yes 2 X No Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 700 Cotter Road Items 23a 21060 USA Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. ant If item 27 ie marked other then "natural", or Items 23. 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White etc. 1 XYes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes ŽXNo White Specify: 3XXVidowed 4 □ Divorced WWII 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Manufacturer Decorative Laminates 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Robert Glenn Denton Eunice Bennett 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William H. Moore (Step-son) 700 Cotter Road, Glen Burnie, MD 21060 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State 6 Department of Important: If any injury or once. 4-23-05 1 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Baltimore, MD 21. Signature of Euneral Service Licensee 22. Name and Address of Facility atri Hardesty Funeral Home P.A. 12 Ridgely Avenue, Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician MYOCARDIAL disease or condition resulting in death) Sudden /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760, Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4 Pregnant at time of death 5 Other (specify) P.O. I 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, DISEASE-1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? page 2 autopsy performed? 2 1 No 1 Tyes 2 **1** No 1 Yes Hospitel or Attending Physicien: 25. Was case referred to medical examiner? 26. Place of Death | Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification; To 1 Yes 2 No 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 DNatural 5 Pending М 1 Yes 2 No investigation 2 Accident within 24 hours after deat To the Funerel Director: completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) adaranis 30. Name and address of person who completed cause of death (Item 23a) Type, Print) 1406 South Crain Highway, Glen Burnie, MD 21061 Alvin S. Madarang, MD 31. Date filed (Month, Pay, Year)

DHMH 17 Rev 1/2001

Registrar

32. Restrar's Signature

7 2005

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item#20b, perFII, C843, 5/2/05 TT State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death DIAMON APRIL **Physician** GWENDOLYN 1107 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 7. Age (In yrs. last birthday) MONE If Under 24 Hrs. our 5. Social Security Number 6. Sex 8. Date of Birth 9 Birthplace (State or Foreign **Funeral** 1 M 2 Months Days Hours Min. 313-64-040 Usual Residence of Decedent Yrs. Director the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits item 27 is marked other than "natural", or itsms 23s or 28s-f show other traumatic event, the Modical Examiner must be notified at 1 XYes 2 □ No Maryland Directo more 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?  $\mathcal{A}$ 21 ol death Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1X Never Married 2 Married 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Governmen 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 91 lamono 19a. Informant's Name/Relationship (Type, Print) (drughter) 19b. Mailing Address (Street and Number or Rure Route Number, City or Town, State, Zip Code) 392 VIa 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 Removal from State GreenMount 4/29/20<u>05</u> A □ Donation 5 □ Other (Specify) rematery 22. Name and Address of Facility Home, o. Md. 2 Funeral t 23a. Part I Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ATHEROSCLEROTIC CORONARY ARTERY **Physician** DISEASE disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the attending physiclan and hed for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year Day 4☐Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ cate has been sign, page 2 should be DIABE 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy 2**X** No 1 Yes Hospital or Attending Physician: the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one, examiner? Hospital: Other: 3 DOA 1 ☐ Inpatient 2 ☐ ER/Outpatient 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred Certification: Injury at Work? After 1 | Natural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident efter death 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours e Funeral ( 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the the 29d. Date signed (Month, Day, Year) 29c. License number 18 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BOLGIANO 2000 W BALTIMORE S EDWARD MD Registrar's Signature 31. Date filod (Month, Day, Year) State 7 2005 APR 2 Registrar

An Sealing Name of not institution; give street and number    Ab City, Town, of Location of Death   Carol Line   Nursing Home   Carol Line   Nursing Home   Carol Line   Nursing Home   Carol Line   C			For State Registrar	State of Maryland		artment of H		Re	g. No.	1425
4. City, Town, or Location of Death Caroline Wursing Home  Fundrol Director  Fundrol Director  Caroline Wursing Home  22_2_2_28_653  IND 2  7 Age (in yrs. ast orthology   10 Location		- 13		burn				Month	8, 2005 Year	3. Time of Death 1:12 AM M
Usual Peacetares of Decedent 100. Inside City Limse 100 Denton 101. Steel and Number 102. Steel and Number 103. Steel and Number 104. Steel and Number 105. Steel and Number 105. Steel and Number 105. Steel and Number 106. Steel and Number 107. Tan Code 110. Steel and Number 110. New Number 110. N	Examin	-	Caroline Nursing  5. Social Security Number  6. Sex	Home 7. Age (In yrs. le		If Under 1 Year	Denton If Under 24 Hrs.		Carolin	place (State or Foreign
James E. Eastburn    Sa. Informant's NamePelationship (Type, Print)   19b. Mailing Address (Street and Number or Hursi Route Number, City or Town, State, Zip Code)   13419 Route 313 Greensboro, Md 21639			Usual Residence of Decedent  10a. State 10b. County	10c. City	, Town or Lo	cation		Jan 26,		Od. Inside City Limits
James E. Eastburn    Sa. Informant's NamePelationship (Type, Print)   19b. Mailing Address (Street and Number or Hursi Route Number, City or Town, State, Zip Code)   13419 Route 313 Greensboro, Md 21639	3a or 28a-f s I be notified		10e. Street and Number		Denc		21629	10		
James E. Eastburn    Sa. Informant's Name/Felationship (Type, Print)   19b. Mailing Address (Street and Number or Hural Route Number, City or Town, State, Zip Code)   134.19   Route   313   Greensboro, Md 21639	al', or Iteme 2	þ	1 Never Married 2 Married	Armed Forces? 1 XYes 2 No				pecify Yes or No- pecify Yes or No- pecify Yes or No-	14. Race - Americ Black, White,	etc.
James E. Eastburn    Sa. Informant's NamePelationship (Type, Print)   19b. Mailing Address (Street and Number or Rural Route Number; City or Town, State, Zip Code)   134 19 Route 313 Greensboro, Md 21639	than "naturi the Medical E	ompleted	(Specify only highest grade	College (1-4or 5+)	(Give life.	kind of work done DO NOT use retired	ation during most of word d)	king		dustry
Approximate Interest to design of conditions, shock, or heart failure. List only one cause on each line.    Approximate Interest Between Onset and Death   Content of the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.    Approximate Interest Between Onset and Death   Content of the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.    Approximate Interest Between Onset and Death   Content of the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.    Approximate Interest Between Onset and Death   Content of the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.    Approximate Interest Between Onset and Death   Content of the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.    Approximate Interest Between Onset and Death   Content of the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.    Approximate Interest Between Onset and Death   Content of the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.    Approximate Interest Between Onset and Death   Content of the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.    Approximate Interest Between Onset and Death   Content of the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.    Approximate   Content of the mode of dying, such as cardiac or respiratory arrest, list one of the mode of dying. Such as cardiac or respiratory arrest, list one of the mode of dying. Such as cardiac or conditions.   Approximate   Content of the mode of dying. Such as cardiac or conditions.   Content of the mode of dying. Such as card	Mental Hygi varked other vatic event.	Be	James E. East		10h Maili	an Address (Street	Elizabe	th Thoma	S	a Code)
Approximate Internal Between Chase Area (allure). List only one cause on each line.    Approximate Internal Between Chase Area (allure). List only one cause on each line.	of Health and litem 27 is rr r other treum		Edgar Eastburn/so	n 20b. Pt	134 lace of Dispo	19 Route	313 Gree	nsboro, l	4d 21639	
Approximate shock, or heart failure. List only one cause on each line.    Approximate shock, or heart failure. List only one cause on each line.   Approximate shock, or heart failure. List only one cause on each line.   Approximate shock, or heart failure. List only one cause on each line.   Approximate shock, or heart failure. List only one cause on each line.   Approximate shock, or heart failure. List only one cause on each line.   Approximate shock, or heart failure. List only one cause on each line.   Approximate shock, or heart failure. List only one cause on each line.   Approximate shock, or heart failure. List only one cause on each line.   Approximate shock, or heart failure. List only one cause on each line.   Approximate shock, or heart failure. List only one cause on each line.   Approximate shock, or heart failure. List only one cause on each line.   Approximate shock or heart failure. List only one cause on each line.   Approximate shock or heart failure. List only one cause on each line.   Approximate shock or heart failure. List only one cause on each line.   Approximate shock or heart failure. List only one cause on each line.   Approximate shock or heart failure. List only one cause on each line.   Approximate shock or heart failure. List only one cause on each line.   Approximate shock or heart failure. List only one cause on each line.   Approximate shock or heart failure. List only one cause on each line.   Approximate shock or heart failure. List only one cause on each line.   Approximate shock or heart failure. List only one cause on each line.   Approximate shock or heart failure. List only one cause on each line.   Approximate shock or heart failure. List only one cause on each line.   Approximate shock or heart failure. List only one cause on each line.   Approximate shock or heart failure. List only one cause on each line.   Approximate shock or heart failure. List only one cause on each line.   Approximate shock or heart failure. List one cause of each line.   Approximate shock or h	Department Important: If any injury or once.		• 4 ☑ Donation 5 ☐ Other (Specify)	. 11	S S	2. Name and Addre tate Anat altimore.	ss of Facility Omy Board MD 2120	d 655 W.	Baltimore S	Street
d	Medical xaminer	amlner	shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, Lading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequence).	uence of):		ng, such as cardiac	or respiratory arre	st,	Interval Between
24a. Was an autopsy performed?  1 Yes 2 No 3 Probably 4 Unknow  24a. Was an autopsy performed?  1 Yes 2 No  25. Was case referred to medical examiner?  1 Yes 2 No  26. Place of Death (Check only one)  27. Place of Death (Check only one)  28. Place of Death (Check only one)  29. Place of Death (Check only one)	e attending phi d for use as th	व	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	d	ncy death 3[		у			,
25. Was case referred to medical examiner?  1   Yes   2   No   Hospital:	been signed by should be detar	eted by Ph		-				1 XY8	s 2□No 3□Pro	babiy 4 DUnknow
w 5 0 1   Yes 220 No 1   Inpatient 2   EH/Outpatient 3   DOA 4 Nursing Home 5   Hesidence 6   Other (Specify)	srtificate has	a	evaminer?					autops perform 1 🗌 Yes 2	prior to co death? No 1 Yes	mpletion of cause of
	s p	2	1 Yes 2 No  27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury	28b. Time o	of 28c. Inju	ry at rk?	28d. Describe ho	w injury occurred	
	within 24 I To the Fu completely	Medical	29b. Signature and title of certifier	and manner stated.		29c. Licens	se number	25	d. Date signed (Month,	Day, Year)
			30. Name and address of person who c	ompleted cause of death (Item	1 23a) (Type	, Print)			,	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 2005 Rebecca 23 Ensor 11:30 May Apri /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Hospital Corke Rosedale Baltimare If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Oct. 5,1916 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □ M 2 □ F Director 217 32 8177 88 Yrs. Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits rai', or itema 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 ☐ No Be Completed by Funeral Director Maryland Baltimore Middle River 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 27 Compression Court 21220 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. I other than " Elementary/Secondary (0-12) College (1-4or 5+) Nurse Hospital permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if Item 27 is marked oth any injury or other traumatic event QDC8. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) W. George Ensor Effie P. Ensor 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lewis Ensor (brother) 14841 Braeburn Road Tustin, California 92780 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Donation 5 Other (Specify) Black Rock Cemetery Apr 26,2005 Butler, Maryland 22. Name and Address of Facility 21. Signative of Funeral Service License Bruzdzinski Funeral Home PA 1407 Old Eastern Avenue Essex, Maryland 21221 23a. P. rt1. E for the disease, or c sn ck, o Heart failure. List o Immediat. Couse (Final disease or Endition mplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, y one cause on each line. Approximate Interval Between Onset and Death Physician Endo carditis 8 days /Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events Due to (or as a consequence of): Examine sician and e burial-transit resulting in death) Last Due to (or as a consequence of): Physician/Medical ending physical use as the l IF FEMALE 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant atten for u 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Year Month Day 5 Other (specify) 4 Pregnant at time of death signed by the a 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 \( \subseteq \text{ Yes} \) 2 \( \subseteq \text{ No} \) 24a. Was an autopsy performed? 2 No 1 Yes

AM

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed this After thi death. within 24 hours after death To the Funeral Director: completely filled in by the

Be

P

Certification:

State filed (Month, Day, Year) MD 9000 Franklin State Registrar

25. Was case referred to medical examiner?

29b. Signature and title of certifier

5 Pending

investigation

6 Could not be

1 ☐ Yes 2 🔀 No

27. Manner of Death

1 XNatural

2 Accident

3 Suicide

29a. Certifier (Check only one)

4 Homicide

Hospital:

30. Name and address of person who completed caus of death (Item 23a) (Type, Print)

28a. Date of Injury (Month, Day Year)

Space Drive 32. Registrar's Signature Bloom D. ORIGINAL

1 Inpatient 2 ☐ ER/Outpatient

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

3 DOA

1 ☐ Yes 2 ☐ No

1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number Res 0000

26. Place of Death (Check only one)

Baltimore, Maryland

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

			State Registrar	te of Marylan	-	artment of H		nd Menta		ene2 ()	05	14261
	Physicia	an	1. Decedent's Name (First, Middle, Last)	T	7		-		onth 22	Day 2005	Year	3. Time of Death
	/Medic		John J		Evans				11 22			12:25 AM
	Examin	er	4a. Facility Name (If not institution, give street at Lorien Nursing Home	and number)		4b. City, Town, or Columb		Death		4c. County	of Death	
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. I	ast birthday)	If Under 1 Year Months Days	If Under 24	4 Hrs. 8. Da	te of Birth lonth, Day, Ch 4,	Year)	9. Birthp	place (State or Foreign
	Director		051-22-5804 1⊠ M 2	□F 76	Yrs.	Worth's Days	110013	Mar	ch 4,	1929	Buff	falo, NY
	and wo		Usual Residence of Decedent  10a. State 10b. County	10c. City	, Town or Lo	ocation					1	10d. Inside City Limits
	Maryian 9-f show	tor	MD Howard	C	olumbi	ia						1 □Yes 2 □No
	or 284	Olrec	10e. Street and Number			10f. Zip Code			10	g. Citizen of V	What Cour	ntry?
	s 23a	ral	5837 Wyndham Circle		0 140	2104		. 0 (0 4 )		USA		ladias
336	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiane. Importent: If Item 27 is marked other than "natural', or Items 23a or 28e-f show any injury or other traumatic event, I're Medical Exactl. at most ke notified at ances.	by Funeral Director	1 Never Married 2 Married 15	is Decedent Ever in U. ned Forces? ]Yes 2 □ No 'es, Give ar or Dates:	ì	Was Decedent of Hi If Yes, specify Cuba 1 Yes 2 No	spanic Origi n, Mexican, Specify:	in? (Specify Y Puerto Rican,	es or No- , etc.)		k, White,	can Indian, etc. I <b>it</b> e
5-0	72 ho	eted	15. Decedent's Education (Specify only highest grade comp	pleted)	16a. Dece	dent's Usual Occupa kind of work done of DO NOT use retired	ation during most of	of working		6b. Kind of B	usin <b>e</b> ss/ln	dustry
21215-0036	within ne.	Completed by		llege (1-4or 5+)	_	<i>DO NOT use retired</i> Foreman	)	•		teel anufaci	turer	•
	filed v Hygia other 1	e Co	17. Father's Name (First, Middle, Last)				18. Mother	's Name (First		laiden Suman		
lan	fental rked c	То Ве	John Llewelyn Evans				Gert	rude J	ennie	Fonta	ine	
Maryland	and M		19a. Informant's Name/Relationship (Type, Pr			ng Address (Street a				_	State, Zip	Code)
	and lealth m 27 her tr		Jeane A. Evans - Wif			37 Wyndha	m Cr.	Columi				Ctata
nore	ages I		20a. Method of Disposition  1 □ Burial 2 □ Cremation 3 □ Remove	ol from State	emetery, cre	matory or other place tan Crema		4-22-0		Oc. Location	•	
Baltimore,	permit. P Departme Importen any Injury 2008.		4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service Licensee	4000	Ž	2. Name and Addres	s of Facility	oomis.	Inc.	Alexano		
			23a. Parth. Enter the disease, or complication	s that caused the death		820 Senec					k 14	Approximate
	Physician /Medical	-	resulting in death)	Se on each line.  A L2HEL  Due to (or as a consequ		v De	men	tia				Interval Between Onset and Death
	Examiner	Iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	HYPER	uence of):							
90,	be executed ician and burial-transit	I Examiner	that initiated events c	Due to (or as a consequence		Ilitus.						
68760,	icate be ex physician s the buria	dlcal	d									
P.O. Box (	requires that the death certificate be execul een signed by the attending physician and nouid be detached for use as the burial-trad	by Physician/Me	in the past 12 months?	res, outcome of pregna ∐Live birth 2 ☐ Feta ☐ Pregnant at time of d ☐ Unknown	I death 3	□Ectopic pregnancy □ Other (specify)					te of delive	ery Day Year
	res that the signed by	y Pr	Part II. Dther significant conditions contributions	ng to death but not res	ulting in the u	inderlying cause give	en in Part I.	2	3e. Did tob	acco use cont	ribute to t	he cause of death?
rds	w requires been sign should be								1 🗌 Ye	s 2 No	3 Prot	bably 4 Unknown
Records,	n: The law requicate hes been r, page 2 shout	Completed						_	4a. Was an autopsy perform	ed.	prior to co death?	opsy findings available ompletion of cause of 2 No
Vital	sician: certifica irector,	Bec	25. Was case referred to medical examiner?			0"		of Death (Che	ck only one	)		
of	Phy this	. To	1 ☐ Yes 2 ☐ No Hospita 27. Manner of Death 28s	1   Inpatient 2	ER/Outpatie		4 Nur			nce 6 □Oth		<b>5</b> y)
OU	Jing After funer	tlon	1 Natural 5 Pending 2 Accident investigation	i. Date of Injury (Month, Day Year)	Injury	Worl	k? Yes 2 □ N		763CHD6 HO	w injury occur	180	
Division of	at or Attending after death. I Director: After d in by the fune	Certification:	2 Could not be	Place of Injury - At he building, etc. (Specifical Control of the control of	ome, farm, st	reet, factory, office			ocation (Str lity or Town,		er or Rura	al Route Number,
	To the Hospital or Attentwithin 24 hours after death To the Funeral Director:	dical	one) a	n the basis of examina nd manner stated.	tion and/or ir	nvestigation, in my o	pinion, death	h occurred at t	the time, da	te and place,	and due t	o the cause(s)
	To the within 2 To the complet	×	30. Name and address of person who completed the filed (Month, Day, Year)  APR 2 7 201	)		D 4	246	55	29	APRI	(Month,	Day, Year) 2,2005
4	1/0		30. Name and address of person who completed S450 Knoll November 1	od cause of death (Item	23a) (Type	Columbia	MD	2104	T U	nilim	SAN	My MD.
	Sta Regist	ate rar	APR 2 7 200	32. Registar's Signa	ture	Sperke						

DHMH 17 Rev 1/2001

FIELDS, ELLEN Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760,

			<b>/pe or Print in Bl</b> State of Maryland				•	11000
		1 - State Registrar		Certifica	te of Death	Reg.	No.UU5	14262
Physicia	an	1. Decedent's Name (First, Middle, Last)	16-				Day Year	3. Time of Death
/Medic	al	4a. Facility Name (If not institution, give st	reet and number)	4b. Cib	, Town, or Location of Dear	APRIL 2	3 Zoo 4c. County of Deat	
Examin	er	SINAL HOSPITAL	0		ALTIMOR		NIA	ļ.
Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. las	t birthday) If Und	er 1 Year If Under 24 Hrs	8. Date of Birth	9. Birt	hplace (State or Foreign
Director		Usual Residence of Decedent	14	Yrs.		Dec. 13,1	1930 JYL	aryland
iryland ihow	_	10a. State 10b. County	10c. City,	Town or Location				10d. Inside City Limits
ours atter death with the Maryland rel', or Items 23s or 28a-f show Exammer intelled at	Director	Maryland N/A		saltim	ore	100	Citizen of What Co	1 Yes 2 No
a or 3	Dir	2707 Norton	ia Pd	101. 2	ip Code	10g.	11 < A	suntry?
death	Funerai	11. Marital Status	2. Was Decedent Ever in U.S. Armed Forces?	13. Was Dec	edent of Hispanic Origin? (Secrify Cuban, Mexican, Puer	Specify Yes or No-	14. Race - Ame Black, White	
or Ite	by Fu	1 Never Married 2 Married	1 ∏ Yes 2 <b>⊠</b> No If Yes, Give	1 ☐ Yes		to riloan, sto.,	Specify: T	1 . a /
"neturel",	ted b	3 Widowed 4 □ Divorced  15. Decedent's Educ		16a. Decedent's Us	ual Occupation	16b	. Kind of Business/	Industry
thin 7%	Completed	(Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4or 5+)	(Give kind of w life. DO NOT	rork done during most of wo use retired)	orking		·
filed within Hygiene. Ither then "	Col	17. Father's Name (First, Middle, Last)	2	Dome	STIC WO	me (First, Middle, Maid	rivate	tamilies
ld be f ental } ked of	To Be	George Pin	nnhrey		Grac	0 500	<del>H</del>	
2 should be filed withir and Mental Hygiene. Is marked other then aumatic event, the M	⊢	19a. Informant's me/Relationship (Typ	Pri (daughter)	19b. Mailing Addres	ss (Street and Number or R	ural Route Number, Ci	ty or Town, State, 2	Zip Code)
es 1 and 2 of Health a litem 27 Is r other tra		Ms. Theresa V	Viggins	4308 S	eminole	Ave. Ba	Ho. Ma	1.21229
Pages 1 nent of H int: If ite		20a. Method of Disposition  1 X Burial 2 □ Cremation 3 □ Re	Cen	netery, crematory or	other place) 5/5	Date 200	Location - City or	Town, State
		<ul> <li>4 □ Donation 5 □ Other (Specify)</li> <li>21. Signature of Funeral Service Licenses</li> </ul>	910 Ga	11Son 22. Name a	nd Address of Facility	12005 00	ungs IV	Tills, Ma.
permit. Departi Importi eny inj		Joseph &	Russ	Joseph	W. North Av	uneral H	ome P./ Ma. 2/21	di di
		23a. Pari . Enter the disease, or complic shock, or heart dailure. List only one	ations that caused the death.	Do not enter the mo	ode of dying, such as cardia	c or respiratory arrest,		Approximate Interval Between Onset and Death
Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	SEPSIS					2 days
Examiner			Due to (or as a conseque	nce of):				O
D ==	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a conseque	nce of):				
executed in and ial-transit	xaminer	Cause (Disease or injury that initiated events c. resulting in death) Last	Due to (or as a conseque	nce of):				
eath certificate be exe attending physician a for use as the burial-i	aiE		540 (0) 45 4 55 (150445)	1100 017.				
tificate ng phy as the	ledic							
death certificate be a attending physicia id for use as the bur	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	c. If yes, outcome of pregnance 1 Live birth 2 Fetal d	eath 3 Ectopic			23d. Date of del Month	ivery Day Year
D 00 D	ysic	1 ☐ Yes 2 No 9 ☐ Unknown	4∏Pregnant at time of dea 9□ Unknown	th 5 Other (s	specify)			24)
law requires that the de as been signed by the a 2 should be detached t	y Ph	Part II. Other significant conditions cont	ributing to death but not resulti	ing in the underlying	cause given in Part I.	23e. Did tobacc	co use contribute to	the cause of death?
v requires been sign						1 ☐ Yes	2 □ No 3 □ Pr	obably 40 Unknown
law renas be	Completed					24a. Was an autopsy	prior to o	itopsy findings available completion of cause of
sicien: The law certificate has t irector, page 2 s						performed 1 ☐ Yes 25 ☑		25KN0
Attending Physicien: r death. ector: After this certific by the funeral director.	o Be	25. Was case referred to medical examiner?	spital: 1 1 thoatient 2 E	R/Outpatient 3☐ D	Othor	ath <i>(Check only one)</i> Home 5 \tag Residence	6 ∏Other (Spe	ciful
ding Phy h. After this funeral c	on: To	27. Manner of Death		8b. Time of Injury	28c. Injury at Work?	2Bd. Describe how in		City
tendir leath. tor: Af the fur	catic	1d Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be		М	1 Yes 2 No			
- e = c	Certification:	4 Homicide determined	2Be. Płace of Injury - At hom building, etc. (Specify)	e, farm, street, facto	ry, office	2Bf. Location (Street City or Town, St		ural Route Number,
To the Hospitel c within 24 hours at To the Funeral D completely tilled is		29a. Certifier SCertifying Physic	cien: To the best of my knowl	edge, death occurre	d at the time, date and plac	e, and due to the cause	e(s) and manner as	stated.
the Hi hin 24 the Fu	Medical	one)	er: On the basis of examinatio and manner stated.					
To Too	1	29b. Signature and title of certifier	0 11	2	9c. License number		Date signed (Monti	
		1/10 10 1	O MAD		RFS COC	D An	0211 5	13 2005

Registrar

DHMH 17 Rev 1/2001

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Komal Lawrence MD, 2401
31. Date filed (Month, Day, APR 2 7 2005 Registres Signature

			State of Maryland / Department of Health and Me	ental Hygier	ie	
			1 - State Registramend item #8 per fh g842 4/ Septificate of Death	Reg. N	(o.) n n c	11000
Н	Physicia		Dosednia riama (riama propinsi	2. Date of Death Month	ay Year	3, Time of Death
	/Medic	al .		APRIL 2	+	
	Examin	er	4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death	4	lc. County of De	
	-		NORTH WEST HOSPITAL RANDAUS TOWN  5. Social Security Number 6. Sex. 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.	8. Date of Birth 1	912 9.B	inthplace (State or Foreign
	Funeral Director		212-03-0599 1 M 2 F 93 Yrs. Months Days Hours Min. 0	1/23/2 <del>005</del>		MD
	D		Usual Residence of Decedent			
	show	_	10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
	Ne M	ecto	MD BALTIMORE BALTIMORE	1.0	200	1 ☐ Yes 2 No
	a or a		10e. Street and Number 10f. Zip Code	10g. (	Citizen of What (	
	ns 23	era	130 SLADE AVENUE APT. #505 21208  11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Spec	cify Yes or No-	U.S.A	nerican Indian,
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or Items 23a or 28e-f show any injury or other treumetic event. It Medical Examinar must be notified at once.	by Funeral Director	Armed Forces?  1 Never Married 2 Married   1 Yes 2 No   1	Rican, etc.)	Black, Wi	nite, etc. VHITE
2-0	72 hc natur	Completed	15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of workin	16b.	Kind of Busines	s/Industry
2	vithin ne. <b>han</b>	mpi	Elementary/Secondary (0-12) College (1-4or 5+) life. DO NOT use retired)		c Doct	AL CEDUTOE
2	iled v Hygie Iher t nt. In		12 SUPERVISOR  17. Father's Name (First, Middle, Last) 18. Mother's Name	(First, Middle, Maid		AL SERVICE
Maryland	d be antal sed o	o Be	JOSEPH FEINGLASS ESTHER	(* ****, ***********	on Camano,	BIRNBAUM
37	shoul nd Me mark	2	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural	Route Number, City	or Town, State	
ž	alth a alth a 27 is		JANET FEINGLASS / WIFE 130 SLADE AVENUE APT. #	505 BALTI	MORE. M	D 21208
ore,	of He of He fitem r oth				Location - City	
Ĕ	Pagement ant: h ury o		`4 Donation 5 □Other (Specify) CHIZUK AMUNO CONG. 104/26	/2005 BAL	TIMORE,	MD
Baltimore,	permit. Depart Import any inj		21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL 8900 REISTERSTOWN R			
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or shock, or heart failure. List only one cause on each line.	r respiratory arrest,		Approximate Interval Between
	Physician	7	Immediate Cause (Final disease or condition a. Cerebroves cultur accultur for condition a.			Onset and Death
	/Medical Examiner		resulting in death)  Due to (or as a consequence of):			
	CAGIIII.o.	<b>5</b>	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):			
	ted nsit	nine	cause. Enter Underlying Cause (Disease or injury			
,	icate be executed physicien and s the burial-transit	Examiner	that initiated events c.  resulting in death) Last Due to (or as a consequence of):			
68760,	ysicie e bur	dicai	d			
			TOTAL TOTAL			
Вох	death certific e attending p ed for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy  1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy		23d. Date of c	
П	0 0 0	sici	In the past 12 months?  1 □ Yes 2 □ No 9 □ Unknown  9 □ Unknown  9 □ Unknown		Month	Day Year
<u>Ф</u>	that the		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e Did tobaco	n use contribute	to the cause of death?
ecords,	se us	d by	The second secon		2□No 3□	
cor	w require been si should b	ompleted		24a. Was an	24h Wara	autopsy findings available
$\alpha$	The lav ate has page 2	duic		autopsy performed;	prior t	o completion of cause of
Vital	iclan: T certificat ector, pa	ပ	25. Was case referred to medical 26. Place of Death	(Check only one)	Vo 1 □ Y	as 2X No
<u> </u>	Si Si	To B	examiner?	ne 5 Residence	6 □Other (S)	pecify)
n of				8d. Describe how in		
Sio	or Attending ifter death. Director: Afte	catio	2 Accident investigation M 1 Yes 2 No			
Division	of or Attences after death is after death in Director: din by the in the incomplete after the incomplete after the incomplete after the incomplete after after a the incomplete after a	Certification:	4 Homicide determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	l8f. Location (Street City or Town, St	and Number or ate)	Rural Route Number,
	To the Hospitel or / within 24 hours after To the Funeral Direction completely filled in b	Medical C	29a. Certifier (Check only one)  1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, a 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	and due to the cause and at the time, date a	(s) and manner and place, and d	as stated. ue to the cause(s)
	To the within 2 To the comple	Me	29b. Signature and title of certifier 29c. License number	29d. [	Date signed (Mo	nth, Day, Year)
)	1 /11		D0059736		toni 2	2 2005
V	110		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		1	
1		10	1031111	5401 000	COURT	ROAD
	Sta Registr		31. Date filed (Month, Day, Year)  32. Registrar's Signature  APR 2 7 2007			

			For State Registrar	State of M		artment of Heal			iene	05	14264
	Physicia /Medic	al	1. Decedent's Pane (First, Middle, Las.	GAU	THUER	,		2. Date of Deat APRIL	2 <sup>Day</sup>	2005	3. Time of Death
)	Examin	er	4a. Facility Name (If not institution, give  Northwest  5. Social Security Number 6. Se	Hospital		4b. City, Town, or Loca Randall If Under 1 Year   If Un		8. Date of Birth	Bal	timore	
	Funeral Director		Usual Residence of Decedent	□ M 2□ <b>X</b> F	70 Yrs.		urs Min.	May 25,	1934		ace (State or Foreign try) York
h the Maryla	r 28a-f shov enctified at	Director	Md. Baltimo  10e. Street and Number		Owings				0g. Citizen o		od. Inside City Limits 1 ☐ Yes ZHNo  try?
<b>5-0036</b> 72 hours after death with the Maryland	"natural", or items 23e or 28e-f show idical Everth at most be multipol at	by Funeral	5002 Willow Bra  11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	nch Way,  12. Was Deceden Armed Forces 1 Tyes 2 1 Tyes, Give Year or Dates:	t Ever in U.S. 13.	21117  Was Decedent of Hispani If Yes, specify Cuban, Me  1 Yes 2 № No Spe	ic Origin? (Spe exican, Puerto f	cify Yes or No- Rican, etc.)	14. R	.S.A. ace - Americ lack, White, of	etc.
<b>2121</b> od within	then "	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)	ucation de <i>completed)</i> College (1-4or	(Give life.	dent's Usual Occupation kind of work done during DO NOT use retired) Nurse	most of workir	ng	16b. Kind of Oral	Business/Inc	,
yland ould be file		To Be (	17. Father's Name (First, Middle, Last)  Wilfred Va.				Flore	(First, Middle, M	ney		
	of Health an Fitem 27 is r other treu		19a. Informant's Name/Relationship (7.  Susan Adams — Day  20a. Method of Disposition  1 □ Burial 2 MiCremation 3 □	ughter	20b. Place of Disponentery, cre	matory or other place)	g Oak (	Ct., Rei	sters	town,	Md. 21136 wn, State
Baltimore,	ant:		4 □ Donation 5 □ Other (Specify, 21. Signature of Funeral Service Licens	)	Metro C	rematory  2. Name and Address of F  Eckhardt Fu  11605 Reist ter the mode of dying, suc	acility	7, 2005 Chapel,	DΛ	2	1117
Ex	ohysician and Medical xaminer the prijar-transil	dical Examiner	23a. Part Lenter the disease, or compositions, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or a	wic Europe of):	ephalip Ausi	all	- Toophidoly and			Interval Between Onset and Death
I Records, P.O. Box 68760, The law requires that the death certificate be executed.	by the attending phitached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Ves 2 □ No 9 □ Unknown		2 Fetal death 3	Ectopic pregnancy Other (specify)				ate of deliver	ry Day Year
rds, P.	been signed by should be deta	by	Part II. Other significant conditions co	ontributing to death	but not resulting in the u	inderlying cause given in F	Part I.	23e. Did tob		•	e cause of death?
	ficate has been or, page 2 shoul	e Completed							ned?	prior to con death?	rsy findings available inpletion of cause of
Division of Vital or Attending Physicien: T	death. ctor: After this certifica y the funeral director, p	Certification: To Be	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	Hospital: 1 Inpat 28a. Date of Inj (Month, D	jury 28b. Time of Injury	ont 3 DOA Other: 4 [  f 28c. Injury at Work?  M 1 Yes	Nursing Hon	_(Check only one ne 5 ☐ Reside 28d. Describe ho	nce 6 🗆 O		)
oital o	urs afte sref Dir illed in t		4 Homicide determined	building, e	njury - At home, farm, st etc. (Specify)	reet, factory, office		28f. Location (Str. City or Town	, State)		
To the Hos	Fur ely	Medical	(Check only one)  2 Medical Exem	iner: On the basis and manners	of examination and/or in	29c. License num	, death occurre	od at the time, da	ate and place	e, and due to	the cause(s)  Day, Year)
	Y		30. Name and address of person who d	completed cause of	death (Item 23a) (Type,	Print)	_	- KWH	C	l	- 0
	Sta Registr	_	31. Date filed (Month, Day, Year) APR 2 7 2	32. egis	trar's Signature	route					

		•	1- State of Maryland / Registrar		artment of Hi tificate of L			ene g. No.	5	142	65
			1. Decedent's Name (First, Middle, Last)				2. Date of Death		021	3. Time of E	Death
	Physicia		Linda Ann		Giddings		April	15 20	өаr 05	1304	М
<b>)</b>	/Medic Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of Death		4c. County of	Death		
	Exam.	•	7900 Benesch Circle #835		Glen Bu	rnie		Anne	Arur	del	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last.	birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth			ace (State or try)	Foreign
	Director		218–42–9200 1□M 2 <b>XX</b> 59	Yrs.	Months Days	Hours Min.	Jan. 29,	1946		land	
	D		Usual Residence of Decedent								
	nylan how		10a. State 10b. County 10c. City, To	own or Lo	cation				10	od. Inside City	
	B-fs	ē	MD Anne Arundel G1	en Bu	ırnie					1 🗆 Yes	X
	or 28	Director	10e. Street and Number		10f. Zip Code		10	g. Citizen of Wh	at Coun	try?	
	death with the Maryland ms 23a or 28a-f show rrest be rediffed at		7900 Benesch Circle, #835		2106	1		USA			
	ems ems	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. \	Was Decedent of Hi f Yes, specify Cuba	spanic Origin? (Sp	ecify Yes or No-	14. Race - Black	America White,		
õ	hours after turel', or Ite		1 ☐ Never Married 2 🕅 Married 1 ☐ Yes 2 📆 No 		1 ☐ Yes 2 🛣 No	Specify:		Specify:	_	Thite	
Š	urel',	d by	3 ☐ Widowed 4 ☐ Divorced Year or Dates:								
ភ	72 h	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give	dent's Usual Occupa kind of work done of	luring most of wor	king	16b. Kind of Busi	ness/Inc	lustry	
9500-61212	ithin han '	mpi	Elementary/Secondary (0-12) College (1-4or 5+)		DO NOT use retired						
	be filed within 72 ital Hygiene. d other than "ne's event, It a Medical		12 17. Father's Name (First, Middle, Last)	Laboi	cer	19 Mothada Nam	ne (First, Middle, N	Warehou	se		
2	be fi	Be			-			aluen sumame)			
3	should be filed within 72 hours after death with the Marylan nd Mental Hygiene. In marked other than "neturel", or items 23s or 28s-f show matic event, I'm Medical Evarinar nast be redified at	٦	Lonsey A. Fitzwater				Exeline_	A: T A:	-		
Maryland	2 a a 6	7			ng Address (Street a						
	1 and Health em 27 ther to				Telegrap			ern, MD 20c. Location - Ci			
altimore,	Pages 1		Burial 2 Mcremation 3   Hemoval norm State	etery, crer	sition (Name of natory or other place	9) 4-23		LOC. LOCATION - O	ty or to	wii, Olate	
Ē	Pa tmen tent: jury				ematory		-03	Baltimo	re,	MD	
Bail	permit. Page Department of Importent: If any injury or once.		21. Signature of Funeral Service Licenses	22	Name and Addres. Hardesty		Home, P.	Δ.			
_	g 0 2 % d		Jaly WI	_1_	12 Ridge	ly Avenu	e, Annapo	lis, MD	214	01	
			23a. Part1. Enter the disease, or complications that caused the death. Description of the shock, or heart failure. List only one cause on each line.	Do not ent	er the mode of dying	g, such as cardiac	or respiratory arre	est,		Approximate Interval Betw Onset and D	/een
i-	Physician	15 T	Immediate Cause (Final disease or condition						Ĺ	1 Days	
	/Medical		resulting in death)  Due to (or as a consequence)	ce of):							
	Examiner		Sequentially list conditions b.								
	₽ #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	ce of):							
	nd rans	Examin	Cause (Cleases or injury that initiated events c								
Ö,	cate be executed physician and the burial-transit		resulting in death) Last Due to (or as a consequen-	ce of):							
8760,	ate b hysic the b	dicai	d								
9		a a	IF FEMALE:								
Box	ith ce itend	an/	23b. Was decedent pregnant in the past 12 mostite?  1 Live birth 2 Fetal de	ath 3[	Ectopic pregnancy			23d. Date Month		_	ear
о. П	e dea he at	Sici	1 Yes 2 No 4 Pregnant at time of deatr	n 5[	Other (specify)			1410111		,	041
٦.	The law requires that the death certifi are has been signed by the attending page 2 should be detached for use as	Physician/M	9 Unknown			- in Doub	One Did to		uta ta th	a course of de	noth?
Ś	res tha igned be del	by	Part II. Other significant conditions contributing to death but not resulting	ngin the u 	nderlying cause give	en in Part I.		acco use contrib		ably 4 ⊟U	
P.C	v requir been s should	ted	John Pany four parts	7			1 □ Y€	S 211110 3		ably 4 U	IIKIIOWII
Vital Records,	law r as be 2 sh	Completed	Diable Mellitus Typ.	e U	۲		24a. Was a autops	n 24b. We	ere auto	psy findings a npletion of ca	vailable use of
ď	The Tate has page	no.					perform	ned2 de:	ath? ] Yes	2 No	
ita	ysicien: The is certificate director, pag	Be	25. Was case referred to medical examiner?			26. Place of Dea	th (Check only on	6)			
	y s	To	1 Yes 2 No Hospital: 1 Inpatient 2 ER	/Outpatier	nt 3 DOA Othe	er: 4 Nursing H	ome 5 Aeside	nce 6 Other	(Specify	/)	
Division of	ding Ph. After thi funeral		27. Manner of Death 28a. Date of Injury 28 1 Natural 5 Pending (Month, Day Year)	b. Time o	f 28c. Injun World	at c?	28d. Describe ho	w injury occurred	i		
<u>Ö</u>	ath. or: Al	atle	2 Accident investigation		M 1 🗆	Yes 2 ☐ No					
<u> </u>	or Attendater deat	tific	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home building, etc. (Specify)	e, farm, st	reet, factory, office		28f. Location (St. City or Town	reet and Number n, State)	or Rura	/ Route Numb	oer,
	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune.	Certification:									
	ospi hou uner uner	cai	29a. Certifier  (Check only)  1 Certifying Physician: To the best of my knowle 2 Medical Examiner: On the basis of examination								
	To the Hospitel within 24 hours a To the Funerel Completely filled	Medical	one) and manner stated.								
	To t To t	Y	29b. Signature and title of certifier		29c. Licens	e number	2	9d. Date signed (	Month.	uay, Year)	
•	1		Jonathan Johnson 10		100	33811	7	1/22/0.	5		
	01		30. Name and address of person who completed cause of death (Item 23)								
_	10		1406B S. Cruin #304 Glan Be		e no	21861					
		ate	31. Date filed (Month, Day, Year)  32. Figistrar's Signature	θ	1						
	Regist	rar	APR 2 7 2005	E 19	2042						

		-	For State Registrar	State of Ma	ryland / Depa	artment of H		Mental Hygie	2003	14266
	Physicia /Medic		1. Decedent's Name (First, Middle, Last)		ellman			2. Date of Death Month	Day Year	3. Time of Death
	Examin			wiew Med	ical Center	17 11	Location of Death		4c. County of Dea	
	Funeral Director			AM SOF	(In yrs. last birthday) Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, Ye 2/27/194	9. Ba 8 M	nthplace (State or Foreign country) aryland
	e Marylan 3a-f show tiffed at	Director	10a. State 10b. County  Maryland Baltimor	æ	10c. City, Town or Lo	ocation				10d. Inside City Limits 1 ☐ Yes 2 🛣 No
	ath with th		8104 Coyne Drive			10f. Zip Code 21221			Citizen of What C	
980	72 hours after death with the Maryland neturel; or Items 23e or 28e-f show disel Exac, her ment be rollified at	by Funeral	11. Marital Status  1 X Never Married 2 ☐ Married  3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 X N If Yes, Give Year or Dates:	lo	Was Decedent of Hi If Yes, specify Cuba 1□Yes 2∑ No	ispanic Origin? (Sin, Mexican, Puerte Specify:	Decify Yes or No- Dican, etc.)	14. Race - Am Black, Wh Specify:	
Maryland 21215-0036	be filed within 72 hours after death with the Marylan ital Hyglene.  Ide other than "neturel; or Items 23e or 28e-1 show or other than "neturel; or Items 23e or 28e-1 show event. It a Marital Exactination at	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)		(Gîve	dent's Usual Occupa kind of work done of DO NOT use retired	during most of wor	king	o. Kind of Busines	s/Industry
and 21	buld be filed within Mental Hygiene, arked other than "atic event, II a Na atic event, II a Na	Be	12 17. Father's Name (First, Middle, Last)		Labo	orer		ne (First, Middle, Mai	onstruct den Sumame)	ion
	e e e	으	William H. Hellmar 19a. Informant's Name/Relationship (Ty Richard Hellman (			ng Address (Street a	and Number or Ru	White ra/Route Number, C  Da. Maryl		
Baltimore,			20a. Method of Disposition  1 Burial 2 Cremation 3 F  4 Donation 5 Other (Specify)	lemoval from State	20b. Place of Dispo	osition (Name of matory or other place		Date 200	c. Location - City o	
Balti	permit. Page Deportment of Importent: If any injury or once.		21. Signature of Funeral Service Licens	Sallin	22 I	2. Name and Addres Bruzdzins 1407 Old T	ss of Facility Ki Funera Bastern A	al Home PA	sex Mar	yland 21221
	Physician	9 y	23a. Part1. Enter the disease, or combishock, or heart failure. List only of Immediate Cause (Final disease or condition	ications that caused ne cause on each lin	e.	ter the mode of dyin	g, such as cardiac	or respiratory arrest,		Approximate Interval Between Onset and Death
100	/Medical Examiner	10	resulting in death)  Sequentially list conditions, if any leading to immediate	pneun	a consequence of):					Weeks
·00	The law requires that the death certificate be executed to has been signed by the attending physician and tage 2 should be detached for use as the buriat-transit	I Examiner	Sequentially list conditions, if any, leading to immediate cause. Lines Underlying Cause (Disease or injury that initiated events resulting in death) Last	z	a consequence of):			-	-	
x 68760,	eath certificate b attending physic for use as the b	/Medical	IF FEMALE:	d	of programmy					
.O. Box	at the death of by the atten- tached for us	Physician/Me	23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown	1 Live birth : 4 Pregnant at 9 Unknown	2 Fetal death 3	□Ectopic pregnancy □ Other (specify)			23d. Date of de Month	olivery Day Year
<u>α</u>	w requires that been signed b should be deta		Part II. Other significant conditions col	ntributing to death bu	\ i	anderlying cause give	en in Part I. (OUNSTERN	23e. Did tobac	<b>\</b> /	to the cause of death?  Probably 4 □Unknown
Vital Records,		Completed by	herniation, acc	ute ren	al failur	<u> </u>		24a. Was an autopsy performed Yes 2	d? prior to death?	autopsy findings available completion of cause of s
of Vita	Physicien: Th this certificate ral director, pag	To Be	N 182 2 NO	Hospital: Inpatie			er: 4 🗌 Nursing H	th (Check only one)		ecify)
Division	ttending death. ctor: After y the funer	Certification:	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of Injur (Month, Day	y 28b. Time of Injury	M 1 🗆	y at k? Yes 2 □ No	28d. Describe how 28f. Location (Stree		Rural Route Number
Div	To the Hospitel or Attending within 24 hours after death.  To the Funerel Director: After completely filled in by the funer		4 Homicide determined  29a. Certifier Certifying Phy	building, etc	c. (Specify)  of my knowledge, deat	th occurred at the tin	ne, date and place	City or Town, S	State) Se(s) and manner a	s stated.
	To the Howithin 24 I	Medical	(Check only one)  29b. Signature and title of certifier	ner: On the basis of and manner sta	examination and/or inted.	29c. License			and place, and du	
)	7		30. Name and address of person who di	Rating	on BMC eath (Item 23a) (Type,	Print) /	25-00	DO Ap	11125	,2005
	Sta Registi		Ur, Holly Yeathan  31. Date filed (Month Park 2 7 2	32. Posistra 2005	140 Eas- ar's Signature	tein Aven	ive, Bat	timore, M	D 210	124

		-	State of Maryland / Department of Health and M  1- For State Registrar  Certificate of Death		ene 005	14267
			1. Decedent's Name (First, Middle, Last)	2. Date of Death Month		3. Time of Death
	Physici /Medio		Vera Hlatky	ADRIL .	14 Just	1:40 M
	Examin		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death	/	4c. County of Deat	h /
			Lauren (a Riversed bellamp	1	HOLFER	rd
	Funeral Director		5. Social Security Number 6. Sex 1 M 2 F 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Mrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, 02/20/19		hplace (State or Foreign untry) nnsylvania
	and w	}	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
	f sho	5				1 ☐ Yes 2 ☑ No
	the 1	Director	MD Baltimore Baltimore  106. Street and Number 107. Zip Code	10	ng. Citizen of What Co	untry?
	3e or	Ö	6905 Delvale Place 21222		U.S.A.	
	deat deat	Funeral	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent of Hispanic Origin? (Spr. If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - Ame	
36	s within 72 hours after death with the Maryland liene. I than "neturel", or Items 23e or 28e-f show The Medical Examinat must be notified at	by Fu	1 Never Married 2 Married 1 Yes 2 Mo 1 Yes, Specify: 3 Widowed 4 Divorced Year or Dates:	riidari, etc.,	Black, White	nite
21215-0036	2 hou	ted	15. Decedent's Education 16a. Decedent's Usual Occupation		6b. Kind of Business/	
215	within 7 ene. than "n	Completed	(Specify only highest grade completed)  [Give kind of work done during most of work life. DO NOT use retired)  [Give kind of work done during most of work life. DO NOT use retired)	ang		
	- 'E L -	Co	12 Seamtress			s Clothier
ğ	o d a b	Be	17. Father's Name (First, Middle, Last)  18. Mother's Name	e (First, Middle, N	faiden Sumame)	
Z	should be and Mental s marked o umatic eve	၉	Tito Greco  Mary Fr  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rurs		Charles Town Charles	T- 0- 4-1
Maryland	nd 2 sho lith and i 27 is me r treume					
ē,	1 al Hea em the	Į.		Date 2	COD, Mary I	Town, State
OL.	0 0		1 X Burial 2 Cremation 3 Removal from State  1 X Burial 2 Cremation 3 Removal from State  1 Donation 5 Other (Specify)	/2005		
Baltimore,	그 두 본 글	Ī	21. Signature of Funeral Service Licensee  4 □ Donation 5 □ Other (Specify)  Most Holy Redeemer Cern, 04/27  22. Name and Address of Facility E.F	/2005 B	altimore, 1	Maryland Home P A
ñ	Departiment Department		E. G. Harraln 11750 Belair Road -	Kingsvi	lle. Marvl	and 21087
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line.			Approximate Interval Between
	Pnysician		Immediate Cause (Final disease or condition			Onset and Death
	/Medical Examiner		resulting in death)  Due to (or as a consequence of):			
	Lxammer	بد	Sequentially list conditions, if any, leading to immediate b.  Due to (or as a consequence of):			
	ted nsit	nine	cause (Disease or injury			
	al-tra	Examiner	that initiated events c.  resulting in death) Last Due to (or as a consequence of):			
8760,	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	dicail	d			
9	tificat 19 ph) as th	Φ				
Вох	eath certific attending p I for use as	an/N	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy		23d. Date of del	,
	it the dea by the at tached fo	Physician/M	in the past 12 months?  1		Month	Day Year
P.0	that the	Phy	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e Did tob	acco use contribute to	the cause of death?
Records,	signed d be del	d by	Parky coa differed / March mides	1 □ Ye	1.	
Sor	w require been sig should b	ete	a teoparisis	24a. Was ar	70	tongu findinga quallable
Rec	has ge 2	Completed	- Cottopwes is	autopsy perform	prior to death?	rtopsy findings available completion of cause of
Vital		e Co	25. Was case referred to medical 26 Place of Death	1 ☐ Yes 2		2 No
Ş		To B	examiner?		nce 6 Other (Spe	cify)
J of	문 등 등		27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at		w injury occurred	
io	Attending In death.  ector: After by the funer	atio	2 Accident investigation M 1 Yes 2 No			
Division	or Atte	Certification;	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Str City or Town	reet and Number or Ru , State)	ıral Route Number,
	pitel		29a. Certifier 1Scertifying Physician: To the best of my knowledge, death occurred at the time, date and place.			-1-1-1
	To the Hospitel or Attending I within 24 hours after death.  To the Funerel Director: Atter completely filled in by the funer	Medicai	29a. Certifier  (Check only one)    Medical Examiner: On the bast of my knowledge, death occurred at the time, date and place, 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	red at the time, da	iuse(s) and manner as ite and place, and due	to the cause(s)
	To th within To th	Me	29b. Signature and title of certifier 29c. License number	29	9d. Date signed (Mont	h, Day, Year)
)			Ca // Mu MD   027975		4/25/0	5
	1,	)	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	A A A	Le Marc	/ .
			Man Milly an 65 Mac Mit NO	14-el H	w MRO	2/0/9
	Sta Regist	ate	31. Date filed (Month, Day, Year) APR 2 7 2005			
	riegist	L.				

			1 - For State Registrar	State of I	Maryland		artmen	t of H	ealth a	and M	lental Hy		nne	14268
	Physici /Medic		Decedent's Name (First, Middle, La     Mary Ja:		Herr	nann					2. Date of De Month April	Day	2005	3. Time of Death
>	Examir		4a. Facility Name (If not institution, gir	e street and number	ər)		4b. City,	Town, or	Location	of Death			County of De	
		2	Anne Arundel M					napo:					nne Ar	unde1
	Funeral		, , , , , , , , , , , , , , , , , , , ,	Sex 7 1 □ M <b>2/CX</b> F	Age (In yrs. Ia. <b>79</b>	st birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bi	ay, Year)	9. B	irthplace (State or Foreig Country)
	Director		203-18-1830 Usual Residence of Decedent		79	113.					Dec.	23,19	25   F	Pennsylvania
	yland		10a. State 10b. County		10c. City,	Town or Lo	cation							10d. Inside City Limit
	a-fel	ctor	MD Anne A	rundel	Aı	nnapo!	lis							1 □ Yes 2 N
	ith th	Director	10e. Street and Number				10f. Zip	Code				10g. Citiz	en of What C	Country?
	ath w		969 Lanna Way	T				214					SA	
336	be filed within 72 hours after death with the Maryland tal Hygiene. Id other than "natural", or items 23a or 28a-1 ehow event. The Modicul Ever in writinal be notified at	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 □ Widowed 4 □ Divorced	12. Was Decede Armed Force 1  Yes 2 If Yes, Give Year or Date	s? <b>X</b> No	- (	Was Deced If Yes, spec 1 ☐ Yes 2	37	spanic Ori n, Mexicar Specity:	gin? (Spe n, Puerto	ecify Yes or No Rican, etc.)		4. Race - An Black, Wh Specify:	nerican Indian, nite, etc. White
21215-0036	2 hou	ted	15. Decedent's E	ducation		16a. Dece	dent's Usua	I Occupa	tion	A - 4 d .:		16b. Kin	d of Busines	s/Industry
2	thin 7 e.	Completed	(Specify only highest gr Elementary/Secondary (0-12)	College (1-4c	or 5+)		kind of wor DO NOT us	e retired)	uring mos	t of work	ing			
7	e filed within al Hygiene. I other than "	Con		2		Homer	naker						Home	
Maryland	be fill ad off	Be	17. Father's Name (First, Middle, Las	•							e (First, Middle		Sumame)	
چّ	ges 1 and 2 should be it of Health and Mental : If Item 27 is marked or other traumatic ev	T <sub>0</sub>	Raymond Gallagh  19a. Informant's Name/Relationship			10h Mailir	a Addross	(Street o			McIlva  McIlva  McIlva  McIlva  McIlva		Town Chair	Tie Code)
g ≥	and 2 st ealth and m 27 ts r her traur		Mark Herrmann (								ton, M			Zip Code)
	f Heal from 2 other		20a. Method of Disposition	3011)	20b. Pia		sition (Nam natory or ot				Date			or Town, State
E 0	Page: ent of nt: If ry or		1 X Burial 2 ☐ Cremation 3 [ 3 4 ☐ Donation 5 ☐ Other (Speci		TA		Vet.			4-28	-2005	Crow	nsvill	e. MD
Baltimore,	permit. Pages Department of the Important: If Ite any injury or of once.		21. Signature of Funeral Service Line				Name and Harde	Addres	s of Facilit Fune	ral	Home, Annap	P.A.		
			23a. Part1. Enter the disease, or con shock, or heart failure. List only	nplications that caus	sed the death.	Do not ent							_ TID	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	^	Directi	10	Poe:	1007	nie					Onset and Death
	/Medical		resulting in death)	, u	as a conseque		1 000	21410	,,,,,,					12 hours
ı,	Examiner		Sequentially list conditions,	b	leus									2 days
	sit sd	Examiner	frany, leading to immediate cause. Enter Underlying	Due to (ur	as a conseque	,	. 1.	1	1					
	ate be executed hysician and the burlal-transit	хаш	Cause (Disease or injury that initiated events resulting in death) Last	c. Pue to /or	as a conseque		SK	101	echu	~				
68760,	be exictant	caiE			ao a oo,,ooqoo									
387	icate phys s the			_ d			-							
P.O. Box (	that the deeth certificate bed by the attending physic detached for use as the E	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown		2 ☐ Fetal d tat time of dea	leath 3	Ectopic pre Other (spe					23	3d. Date of de Month	elivery Day Year
Records, P.	es jg	by	Part II. Other significant conditions	contributing to death	but not result	ing in the u	nderlying ca	iuse give	n in Part I.			obacco us	/	to the cause of death?  Probably 4 Unknown
CO	law requir as been s 2 should	Completed									24a. Was		24b. Were a	utopsy findings available
He	9 L B	E O									auto perfo	rmed?	prior to death?	
Vital	ysician: Th	BeC	25. Was case referred to medical examiner?						26. Place	of Death	(Check only	1		
ot >	Physician: this certificant	2	1 ☐ Yes 2 ☐ No	Hospital:		R/Outpatien			4 🗆 14 0	rsing Hor	me 5□Resi	dence 6	Other (Sp.	ecify)
sion o	ding F. After fune	Certification;	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	n	njury Day Year) 2	lab. Time of Injury	M 28	Bc. Injury Work 1 🔲 Y	at ? 'es 2 □ l		28d. Describe	how injury	occurred	
Division	Irec Irec	Certific	3 Suicide 6 Could not lead to determine determined	286. Place of	Injury - At hom etc. (Specify)	ne, farm, str	eet, factory,	office			28f. Location ( City or To		Number or F	Rural Route Number,
	To the Hospital or At within 24 hours after d To the Funeral Direct completely filled in by	edicai	29a. Certifier (Check only one)	hysician: To the be miner: On the basis and manner	s of examination	edge, death on and/or in	occurred a vestigation,	it the time in my op	e, date an inion, dea	d place, a th occurr	and due to the ed at the time,	cause(s) a date and p	ind manner a place, and du	as stated. le to the cause(s)
	with To t	Σ	29b. Signature and title of certified				29c.	License	number			1		nth, Day, Year)
	1		Muchy	mo			D	006	017	5		4/23	105	
i	11		30. Name and address of person who		of death (Item 2					-				
7	V		Miccah R. Fisher  31. Date filed (Month, Day, Year)	MD 32 Badi	Anne strar's Signatu	Ann	iled 1	need	ico 1	Ce	nter, f	may	Die 1	no
	Sta Registi		ADD 9 7	2005 32. Regi	oner a orginalu	الم الم		¬(						
DH	IMH 17 Rev 1/2	*	nin 4 (	2003	we h	19								

ORIGINAL

		1 - For State Registrar	State of Ma	aryland / Depa	artment rtificate			and M		giene Reg. No.	2000	1426
Physicia /Medic	al	Decedent's Name (First, Middle, Last)     WILEY J. HASKINS      4a. Facility Name (If not institution, give s			4h City 1	Town or	Location o	of Death	2. Date of Dea	16, Day	2005 Yeer	3. Time of Death
Examino	er	JOHNS HOPKINS HO  5. Social Security Number 6. Sex	SPITAL 7. Age	(In yrs. last birthday)	BAL If Under	TIMC	RE	24 Hrs.	8. Date of Birt	h	N/A 9. Birthi	place (State or Fore
Director		227-52-9079 1X  Usual Residence of Decedent  10a. State 10b. County	XM 2□F	63 Yrs.		Days	Hours	Min.	2-I 6-I	942"	VIRG	ÍŃÍA
the Maryla 28e-f shov	Director	MD N/A		BALTIMOR		Codo			<del></del>	10- 04		10d. Inside City Limi
ath with e 23a or nust be	ral Dir	1401 E. OLIVER S			2	1213				U	zen of What Cou	
S " "	d by Funeral	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☐ N If Yes, Give X Year or Dates:	0	Was Decede If Yes, speci 1 ☐ Yes 2		spanic Orig n, Mexican Specify:	gin? (Spe , Puerto I	city Yes or No- Rican, etc.)		14. Race - Americ Black, White, Specify: BLA	etc.
d within jiene.	Completed	15. Decedent's Educ (Specify only highest grade	cation completed) College (1-4or 5-	(Give	dent's Usual kind of work DO NOT use TCHER	k done d e retired;	urina most	of workir	ng		nd of Business/In	
Mental Hyg arked other atic event,	To Be C	17. Father's Name (First, Middle, Last) PERKINS HASKINS					MAF	RY AN	(First, Middle,	CH		
alth and 27 is my 27 is my sr trauma		19a. Informant's Name/Relationship (Typ. DARRYL HASKINS (S	,								Town, State, Zip ARYLAND	
00.		20a. Method of Disposition  1 XBurial 2 Cremation 3 Re  4 Donation 5 Dother (Specify)		20b. Place of Dispo cemetery, crer KING MEMO	natory or oth RIAL	her place PARK	4-	-23-2		BALT	cation - City or To	ARYLAND
permit. Page Department of Important: If any injury or once.		21. Signature freral Service License	2. Hi	D. HIBNER								P.A. TLAND 2121
	icai Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underfug Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a	consequence of):  consequence of):  consequence of):  consequence of):	si'on	Car etes	dio Me	Vas	culai his	Dis	ease	yeae.
death certific	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	ic. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at t 9 ☐ Unknown	Petal death 3□	Ectopic pre					2	3d. Date of delive	ery Day Year
	ò	Part II. Other significant conditions cont Chemic Rena	nbuting to death bu	t not resulting in the ur	nderlying car	use give	n in Part I.		23e. Did to			ne cause of death?
	Completed							_	24a. Was a autops perton	sy	prior to cor death?	psy findings available inpletion of cause of 2 No
0 0 X	ation; To Be	25. Was case referred to medical examiner?  1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	ospital: 1 Inpatier 28a. Date of Injury (Month, Day	28b. Time of		c. Injury Work	r: 4□ Nur.	sing Hom	Check onl or the 5 Reside	ence 6	Other (Specify	/)
To the Hospitel or Attending Phwithin 24 hours after death. To the Funerel Director: After the completely filled in by the funeral	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Inju- building, etc.	ry - At home, farm, stre (Specily)	eet, factory,	office		2	8f. Location (Si City or Town		Number or Rura	l Route Number,
ne Hospitel no 24 hours a no Funerei I	edicai	29a. Certifier (Check only one) 1 Certifying Physical Exemination (Check only one)	cien: To the best of er: On the basis of and manner stat	i my knowledge, death examination and/or inv ed.	occurred at estigation, i	t the time in my opi	e, date and inion, death	l place, ai	nd due to the co	ause(s) a ate and	and manner as st place, and due to	ated. the cause(s)
To the within 2 To the complet	_	29b. Signature and title of eartifier ,	hhus			License	-158		2		signed (Month, 1	
Stat Registra		Jyoth Paris	ch Mo	ath (Item 23a) (Type, I 821 N. Eu Signature	Haw	st	sees	, 8u	ite 4	ο7 <sub>1</sub>	Baltimo	ee, MD 212

			State of Maryland	/ Depa				2001	11.27	
Physici /Medic Examir	cal	Decedent's Neme (First, Middle, Last)     Mary C. Jones     Aa. Facility Name (If not institution, give s     609 Light House I			4b. City, Town, or Location of		Day L 17, 2	2005 County of Deett		
Funeral Director		5. Social Security Number 6. Sex	7. Age (In yrs. las M 2∏F 85	t birthday) Yrs.	If Under 1 Year   If Under 2 Months Days Hours	Min. 8. Date of (Month) Mar 8	f Birth Day, Year)		oplace (State or Foreign untry) ginia	
be filed within 72 hours after death with the Maryland tall Hygiene. and other than "natural", or iteme 23a or 28a-f ahow event, the Medical Examinar must be multiped at	il Director	10a. State 10b. County MD Anne. Arus 10e. Street and Number 609 Light House L			apolis  10f. Zip Code  21401		10g. Citi	zen of What Coo	10d. Inside City Limits 1 ☐ Yes 2 ☑ No untry?	
ithin 72 hours after death han "natural", or Itame 2 a Medical Examinat must	d by Funeral		Was Decedent Ever in U.S. Armed Forces?     □ Yes 2 ☑ No If Yes, Give Year or Dates:	n U.S. 13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☒ No Specify:			)	ncan Indian, e. etc. ite		
d within 72 hours after giene. r than "natural", or ita tha Medical Examira	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) 1 2	of working		nd of Business/i financi;					
2 should be filed to and Mental Hygie 1e marked other fraumatic event, the	To Be C	17. Father's Name (First, Middle, Last)  John Manning Bark  19a. Informant's Name/Relationship (Tyx	an Hill	ume (First, Middle, Maiden Surname) Hill Franklin Bural Route Number, City or Town, State, Zip Code)						
and ealtr m 27	Elaine Cherneski/daughter  609 Light House Landing Lane  20a. Method of Disposition  1 Burial 2 Cremation 3 Removal from State									
permit. Pages 1 ar Department of Hea Important: If Item eny injury or othe		4 Donation 5 □ Other (Specify)  21. Signature   Funeral Service License Rolls		St	Name and Address of Facility Late Anatomy Bo Litimore, MD 2	ard 655	W. Bal	timore	Street	
Physician /Medical Examiner		23a. Pan 1. Enter the disease, or complic shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	ations that caused the death. e cause on each line.  Due to (or as a consequent	em	er the mode of dying, such as c	ardiac or respirato	ry arrest,		Approximate Interval Between Onset and Death	
ite be executed ysicien and ne burial-transit	ical Examiner	d								
The law requires that the death certificate is the bas been signed by the attending physion age 2 should be detached for use as the teach.	hysiclan/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 \( \triangle \text{Yes} \) 2 \( \triangle \text{No} \) 9 \( \triangle \text{Unknown} \)	ic. If yes, outcome of pregnance 1 □ Live birth 2 □ Fetal de 4 □ Pregnant at time of deat 9 □ Unknown	eath 3	Ectopic pregnancy Other (specify)			3d. Date of deli Month	very Day Year	
w requires that the debeen signed by the should be detached	by P	Part II. Other significant conditions con  Coronary art	1	ng in the ui	nderlying cause given in Part I.	_	I ☐ Yes 2	□No 3 Pro		
. 48 17	e Completed	25. Was case referred to medical			26. Place		Mas an autopsy performed? es 2 □ No	24b. Were aut prior to death? 1 \(\sum \text{Yes}\)	copsy findings available completion of cause of 2 1 No	
ling Phys n. After this funeral di	ertification: To B	27. Manner of Death  1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigation	ospital: 1 Inpatient 2 EF  28a. Date of Injury (Month, Day Year)	VOutpatien Bb. Time of Injury	t 3 DOA Other: 4 Nurs	sing Home 5 121	-		ify)	
e Hospital or Attending 24 hours after death. e Funeral Director: Afte lately filled in by the fune	O	3 Suicide 6 Could not be determined  29a. Certifier 1 Certifying Phys	28e. Place of Injury - At home building, etc. (Specify) ician: To the best of my knowle			City of	Town, State)		ral Route Number,	
To the Hospital within 24 hours a To the Funeral I completely filled	Medical	(Check only 2 Madicel Exeminate)  29b. Signature and title of certifier	er: On the basis of my knowledger and manner stated.				me, date and	place, and due	to the cause(s)	
		30. Name and address of person who co	erpleted cause of death (Item 2)	011	Print) Solomons [	sland K	d Ann	apo (15	2005 on 2/42/	
Sta Regist	ate rar	31. Date filed (Month, Day, Year) APR 2 7 2005	32. Registrar's Signatur	perk				, ,		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death TAMI LYNN JANSSEN APRIL 23 2005 6:30P /Medical 4a. Fecility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner National Institute of Health Montgomery Bethesda 8. Date of Birth (Month, Day, Year) May 10, 1983 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Birthplace (State or Foreign
Country) Months Days Hours 1□M 25√F 241-57-1092 21 May Nebraska Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits NCGaston Gastonia 1. Yes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2509 Castlewood Drive 28056 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married White 1 ☐ Yes 2 No Specify: Š 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Student College 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Betty Betten Doyle Janssen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2509 Castlewood Drive Gastonia, N.C. 28056 Doyle Janssen/Father 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Removal from State 2 □ Cremation 3 □ Removal from State Evergreen Cemetery 4/28/05 Belmont, N.C. 4 ☐ Donation \_5 ☐ Other (Specify) 21. Signature of Funeral Service Licer PATTIP AD SERVICE, P.A. 9241 Columbia Blvd.Silver Spring, Md20910 23a. Part1. Enter the liseese, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ACUTE MYELOID LEUKEMIA 13 MONTHS Due to (or as a consequence of): PAILURE MONTH ACUTE RENAL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner 3 WEEKS PNEUMONIA Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ■ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Linknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Tes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy perform 1 Yes 2 No 1 Yes 2X No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 ☐ Yes 2 X No 1 KInpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28c. Injury at Work? Certification: 28d. Describe how injury occurred Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number (MD) 29b. Signatuse and title of certifier 29d. Date signed (Month, Day, Year) B. N. Savani 23 2005 D0060419 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SAVANI N 10 CENTER DRIVE, BETHESDA, MARYLAND 20892

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

To the Hospitel or Attending within 24 hours after death.

To the Funerel Director: After

Director:

Physician

**Funeral** 

Director

7 is marked other than "naturel", or items 23a or 28e-f show traumatic event, the Modical Exerciner must be notified at

permit. Pages 1
Department of H
Important: if ite
eny Injury or otl

**Physician** 

/Medical

Examiner

attending physician and for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

death with the Maryland

Baltimore, Maryland 21215-0036

32. Registrar's anature

		For State Registrar	State of Ma		Dep		Health ar	d Mental Hy	_	5 14272							
Physicia /Medica Examine	al .	Decedent's Name (First, Middle, Last)     Lesley R. Joyner      A. Facility Name (If not institution, give state)	street and number)			4b. City, Town,	or Location of [	2. Date of D Month	Day Ye 23, 200	15 11:43p							
Funeral Director		5. Social Segurity Number 6. Sey 1X Usual Residence of Decedent		(In yrs. last t	Yrs.	If Under 1 Year Months Days	If Under 24 Hours	Hrs. 8. Date of 8 Min. 04-05-19	irth Pay, Year) 9. 940 No	Birthplace (State or Foreig Country) rth Carolina							
the Maryland 28a-f show	Director	10a. State 10b. County MD NA 10e. Street and Number		10c. City, To	wn or L	re			10d. Inside Ci								
3a or	ם ב	3928 Fairview Avenue				10f. Zip Code 212	16		10g. Citizen of What	Country?							
within 72 hours after death with the Maryland jiene. Ithan "natural" or Itema 23e or 28e-f show the Muulcal Examinar munt be notified at	d by Funeral	1 Never Married 2 🕅 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 No If Yes, Give Year or Dates:			Was Decedent of Hispanic Origin? (Specify Yes If Yes, specify Cuban, Mexican, Puerto Rican, e  1 ☐ Yes 2 🕱 No Specify:  edent's Usual Occupation											
within 72 lene. then "net he Medica	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)			a. Dece (Give life.	dent's Usual Occu kind of work done DO NOT use retire	pation during most of d)	working	16b. Kind of Busine	ss/Industry							
be filed htal Hyg ed othe event,	To Be Co	12 17. Father's Name (First, Middle, Last) Isaac E. Joyner			]	aborer		Name (First, Middle	Bethlehe e, Maiden Surname)	m Stee1							
and and le m		19a. Informant's Name/Relationship (Ty, Leslie Joyner/ Daughte	•	19		-	and Number o		ber, City or Town, Stat	e, Zip Code)							
Page ment o	ĺ	20a. Method of Disposition  1   Burial 2 □ Cremation 3 □ R  4 □ Donation 5 □ Other (Specify)			of Dispo	osition (Name of matory or other pla emetery	се)	Date -30 -05	20c. Location - City Sharpsburg,								
permit. Pag Department Important: I any injury o		21. Signature of Funeral Service License	oues )	_		2. Name and Addre vlie Funera		38 N. Gilmor	St. Baltimo	re, MD 21217							
Physician /Medical Examiner  populari-transit	Ä	23a. Pant1. Enter the disease, or combi- shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a	e.  DY OV C  a consequence  consequence	SC of): H of):	ular A eart Fa	Ccide		arrest,	Approximate Interval Between Onset and Death							
death certificate e attending phy d for use as the	ca	hysician/Medicai	hysician/Med	hysician/Med	hysician/Med	nysician/Medical	пузісіап/медісаі	nysician/medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1								delivery Day Year
quires tha	۵	Part II. Other significant conditions con	ntributing to death bu	t not resulting	in the u	nderlying cause giv	ven in Part I.			to the cause of death?  Probably 4 Dunknow							
, 42 CF	Completed							24a. Was auto perf 1 □ Yes	ormed? prior death	autopsy lindings availab to completion of cause of ? es 2 \square No							
ng Physicia fter this cert ineral direct	ation: 10 Be	25. Was case referred to medical examiner?  1  Yes 2  Ho  27. Manner of Death 1  Actural 5  Pending 2  Accident investigation	ospital: 11 Inpatier 28a. Date of Injur (Month, Day	y 28b.	utpatier Time o Injury	f 28c. injui Wo	er: 4□ Nursir y at k?		one idence 6 □Other (S how injury occurred	pecify)							
after des Director	Certification:	3 Suicide 6 Could not be 4 Homicide determined							(Street and Number or wn, State)	Rural Route Number,							
To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the t	edical C	29a. Certifier 1 Certifying Phys	sician: To the best of ner: On the basis of and manner sta	examination a	e, deat	h occurred at the til vestigation, in my o	me, date and p pinion, death o	lace, and due to the occurred at the time,	cause(s) and manner date and place, and c	as stated. lue to the cause(s)							
To the complete compl	Z =	29b. Signature and title of certifier	>			29c. Licens	e number		29d. Date signed (Mo	onth, Day, Year)							
				2.2000	ח מיין	89	152'	3	4-23-0	5							
5		30. Name and address of person who co	mpleted cause of de	11. 10.		Print)	eneral	Hospita									
State Registra	e	31. Date filed (Month, Day, Year) APR 2 7 2	32. R distra	r's Signature		perle	uici WI	- wyrau	-1								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend items 19a 20a barrow Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Jenkins **Physician** Month Jonathan 5:40 PM 2005 /Medical 4a. Facility Name (It not institution, give street and number)
Battimove Renabilitation Extended Cave 4b. City, Town, or Location of Death Examiner 4c. County of Death BALTIMORE N/A If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 12-21-1948 9. Birthplace (State or Foreign **Funeral** 1₩ 2□F 219-52-2880 56 MARYLAND Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location item 27 is markad other than "natural", or items 23a or 28a-f show other traumatic event, the Modical Executor must be notified at 10d. Inside City Limits Director MD. N/A 1 Yes 2 □ No BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1313 PRESSTMAN ST. 21217 USA death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∰Yes 2 □ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important; If item 27 Is marked other than "natural", or Item any injury or other traumatic event, the Mudical Even the angles. Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No þ 3 ☐ Widowed 4 ☑ Divorced Specify: BLACK Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) PROGRAMMER ANALYST GOVERMENT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) JAMES T. JENKINS, SR. NAOMI SPRIGGS 19a. Informant's Name/Relationship (Type, Sister 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21244 JACQUELINE GREENE (DAUGHTER) 101 VILLAGE OF PINE COURT 3B BALTIMORE, MARYLAND 20a. Method of Disposition Garrison Forest Vet 5-3-0<del>5</del> Owings Miyol Swn, State XBurial 2 1 3 Removal from State METRO CREMATORY 29-2005 BALTIMORE, MARYLAND \* 4 Donation HIBNER Name and Address of Facility REDD FUNERAL SERVICE 21. Signatu 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or beart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Metastatic -ancer Physician une /Medical Due to (or as a consequence of). **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 Unknown Completed this certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed (es 2 No 2 No 1 ☐ Yes 1 Yes 25. Was case referred to medical examiner? 26. Place of Death Check onl. one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Many r of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation death. M 1 ☐ Yes 2 ☐ No 2 Accident Diractor: 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide ō To the Hospital within 24 hours a To the Funeral Completely filled 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print). Raven Boukevard, Battimore Maryland 31. Date filed (Month, Day, Year) 32. Registres Signature State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** RAYMOND 55-PM KAHLER 22 2005 APRIL /Medical 4a. Fecility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** BALTIMORE BAYVIEW Medical Center NIA Johns HOCKING If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** 10 M 2 □ F Days Hours 9 Yrs. Director 212-22-7330 MD Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. snt: If Item 27 Is marked other than "naturel", or Items 23a or 28a-1 ehow 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits f Health and Mental Hygiene. Item 27 Is marked other than "naturel", or Items 23a or 28a-f ehow other traumatic event, the Medical Exactine must be redified at HARFORD 1 Yes 2 No Completed by Funeral Director Belgia MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? heartham CT. 2300 21015 U. 5. A. 12. Was Decedent Ever in U.S. Armed Forces?

1 Pres 2 No U. 5. Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1□ Yes 2□ Ño Specify: Specify: WhiTe .3 ₩idowed 4 Divorced Year or Dates: ARMY 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) BETE. 13+4 SUPERUISOR 4/4 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be KAHLPR unknown Joseph 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SAMPSON Belair 2300 Shareham CT. Ken 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages Opportment of H Importent: If Ite eny injury or of once. 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4/26/05 RIVER 4 ☐ Donation 5 ☐ Other (Specify) cem. M10012 22. Name and Address of Facility STELLA FUNERAL HOME CHTD. HARTIEY MILLER - STELLA FUNERAL HOME CHTD. 7527 haren RD RD. BAIto. MD 21234 21. Signature of Funeral Service Licenses 2 tella 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician MYOCARDIAL # NFARTCUER disease or condition resulting in death) HOURS /Medical Due to (or as a consequence of): Examiner ARTERN (econging Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Years Due to (or as a consequence of Examiner attending physician and for use as the burial-transit Hospitel or Attending Physicien: The law requires that the death certificate be axecuted Disc 52 Athers coldi Vas Calar Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2☐ No 2 No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ EF/Outpatient 3 ☐ DOA 1 Yes 2₽No 2 this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide within 24 hours a To the Funerel L Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) -25-2005 055306

Registrar

State

RP.

Svite 200 Balt des

G106 Philidelphia

8091890

30. Name a d address of person who completed cause of death (Item 23a) (Type, Print)

2005

ODIE

APR 2

DENHIS -H.

31. Date filed (Month, Day, Year)

			For State Registrar	State of Maryla		artment of H rtificate of L			Reg. No.U U 5	14275		
	Physici	an	1. Decedent's Name (First, Middle, Last,			,		2. Date of De Month	Day Ye	3. Time of Death		
	/Medic	al	EARL			266	1 4 4 19	APRIL		005 3:20 P M		
	Examin	er	4a. Facility Name (If not institution, give		.0.	4b. City, Town, or	ALLS 7		4c. County of	TIMURE		
			5. Social Security Number 6. Se		S. last birthday)	If Under 1 Year	If Under 24	Hrs. 8 Date of Bir	th 9	Birthplace (State or Foreign		
	Funeral Director			M 2□F 74		Months Days	Hours	Vin. (Month, Da Dec 11,	y, Year) 1930 M	lary land		
	D		Usual Residence of Decedent							And tooling O't. I have		
	arylar show	_	10a. State 10b. County		City, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2√ No		
	be M	Director	MD Baltimor	e .	Randa11	S COWN			10g. Citizen of Wha			
	with the party of	ä	10e. Street and Number 5412 Old Court Ro	ad		·	21133		•	SA		
	Jeath Ins 23	Funeral	11. Marital Status	12. Was Decedent Ever in	U.S. 13.	Was Decedent of Hi	spanic Origin	? (Specify Yes or No Puerto Rican, etc.)	- 14. Race -	American Indian,		
9	be filed within 72 hours after death with the Maryland Hygiene. del Hygiene. del Hygiene. del cher than "natural", or tiems 23a or 28a-f show avent, I'm Medical Evacit or rotat be notified at	Ē	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 🕅 No If Yes, Give			n, Mexican, P Specify:	uerto Hican, etc.)	Specify:	White, etc. black		
21215-0036	ural,	Completed by	3 Midowed 4 Divorced	Year or Dates:						111012		
7	"nate	iete	15. Decedent's Edu (Specify only highest grad	cation e <i>completed)</i>	16a. Dece (Give	dent's Usual Occupa kind of work done of DO NOT use retired	ation <i>furing m</i> ost of	f working	16b. Kind of Busin	ness/Industry CITE		
12	withir iene. rthan	Щ.	Elementary/Secondary (0-12)	College (1-4or 5+)	<i>m</i> 6.	plater	/					
	filed Hygid Sther ent,		17. Father's Name (First, Middle, Last)				18. Mother's	Name (First, Middle	. Maiden Sumame)			
<u>a</u>		o Be	Earl Lee Sr				F	Purnell Wa	e1ace			
Maryland	2 8 8		19a. Informant's Name/Relationship (T)	, . ,				or Rural Route Numb		ate, Zip Code)		
- 100	123 E G		Joyce Floyd/siste				Avenu	e Baltimo		1216		
Baltimore	@ ° = 5		20a. Method of Disposition  1 Burial 2 Cremation 3 Removal from State  4 Donation 5 Other (Specify)									
Balt	permit. Pag D. partment Important: ary injury o		21. Signature of Funeral Service Lice s	Wade, Direct	S S	Name and Address tate Anat altimore,	s of Facility Omy Bo MD 2	ard 655 W 1201	. Baltimo	re Street		
	/Medical Examiner	Examiner	Tany, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	a. Due to (or as a consi	OBSTRU					Approximate Interval Between Onset and Death		
P.O. Box 68760,	To the Hospitel or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medical Ex	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No	Due to (or as a consider.  23c. If yes, outcome of pregnular to time or a consider to the constant at time or a constant at time or a constant at time or a constant at time or a constant at time or a constant at time or	nancy stal death 3[	□Ectopic pregnancy			23d. Date of Month	Day Year		
ds, F	uires tha signed I Id be det	by	Part II. Other significant conditions co		_	underlying cause give				ute to the cause of death?		
Records,	The law requir ite has been si bage 2 should	Completed						24a. Was auto peri 1  Yes	s an 24b. We priormed? de:	ore autopsy findings available or to completion of cause of ath?  Yes 2 □ No		
Vital	ysician: The is certificate hi director, page	Bec	25. Was case referred to medical examiner?				26. Place o	Death (Check only	one)			
of <	hysic his ce I dire	2	1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatient 2			4   Murs	ing Home 5 ☐ Res				
פֿם	ding Ph h. After th funeral	ö	27. Manne of Death 1 → atural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Wor			how injury occurred			
Division	or Attenditer death	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At building, etc. (Spe	home, farm, st		Yes 2□No	28f. Location	(Street and Number wn, State)	or Rural Route Number,		
	To the Hospitel or Attenwithin 24 hours after deatl to the Funeral Director: completely filled in by the	Medical Ce	(Check only 2 Medical Exam	sician: To the best of my k	nowledge, dea	th occurred at the tin	ne, date and pinion, death	place, and due to the occurred at the time	cause(s) and mann , date and place, an	ner as stated. d due to the cause(s)		
	thin 2 the control	Med	29b. Signature and title of conting	and manner stated.		29c. Licens	e number		29d. Date signed (	Month, Day, Year)		
	F 3 F 8			MA		DS-	1722	-	APRIL	19 2005		
			30. Name and address of person who d	ompleted cause of death (I	tem 23a) (Tvoe	Print)		7 5 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7				
			LEONARD RICHARDSO	N M.D. 5602	BALTIM	ORE NATIO	NAC PIK	E#603 B	ALTIMORE,	MD 21228		
	Sta	ite	LEONARD RICHARDSO 31. Date filed (Month, Day, Year)  APR 2: 7 2005	32. Registrar's Sig	nature	Hi I						
	Regist	rar	APR 2 7 2005	Header D	· STAN	- Paris						

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth **Physician** Maxine Rebecca Lewis APri જ 2005 /Medical 4a Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Center Baltimore 7. Age (In yrs. lest birthdey) Square Rosedale 5. Social Security Number If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) If Under 1 Year Birthplace (State or Foreign Country) **Funeral** Months Deys 1□M 2XF 74 215 28 6388 Director Oct. 15, 1930 North Carolina Usual Residence of Decedent 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Maryland Baltimore Funeral Director Middle River 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 23e or 5 Right Wing Drive 21220 USA 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Yes 2 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0020 ò 1 ☐ Yes 2 No Specify: Specity: White Completed by 3 Widowed 4 Divorced Decedent's Usual Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. Hospital 12 Nursing Assistant 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) and Mental is marked William Blevins Edith Spencer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) Harney L. Lewis (Husband) 5 Right Wing Drive Baltimore, Md. 21220 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State ō 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4/28/2005 Bel Air, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Bel Air Mem. Gardens 22. Name and Address of Fecility
Bruzdzinski Funeral Home P.A. 21. Signature of Funerel Service Licensee 1407 Old Eastern Avenue Essex, Md. 21221 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, (shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical · Inoperable Ischemic Examiner resi Oheral The law raquiras thet tha death certificata be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es e consequence of): Division of Vital Records, P.O. Box 68760 by Physician/Medical Due to (or as e consequence of) Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to Completed Coronary Artery Disease 24a. Was an autopsy performed? completion of cause of death? 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Plece of Death (Check only one) 1 ☐ Yes 2 No Hospital: 1 Inpatient 2 ER/Outpetient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 this 27. Menner of Deeth 28b. Time of Injury 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 3 🗆 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Hospital or Attending Physician: within 24 hours after deeth To the Funeral Director: A completely filled in by the fi To the

Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the ceuse(s) and manner as stated.

| Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2ES 000 April 25, 2005 completed cause of deeth (Item 23e) (Type, Print) 9000 Franklin Square Drive Baltimore, MD, 21237

State Registrar

edicai

			For State Registrar		Sta	ite of I	Marylai	•	artmen ertificat			ind M	lental Hyg	jiene	05	14277
			Decedent's Name	(First, Middle,	Last)								2. Date of Dea	th		3. Time of Death
	Physicia		Henry	Joseph	Ludwi	a							April	24,	2005	9:30 AM
	/Medic Examin		4a. Facility Name (If				er)		4b. City,	Town, or	Location o	f Death	<u> </u>		nty of Death	
	Examin	eı	5235 W.					01	Colu	mbia	a			HO	ward	
	Funeral		5. Social Security Nu		. Sex	7.		last birthday			If Under 2	24 Hrs. Min.	8. Date of Birth (Month, Day	l Yearl	9. Birthp	lace (State or Foreign
	Director		213-07-8	543	1 ₹ M 2	□F	8	7 Yrs.	Months	Days	Hours	WIII).	JUNE 7		Mary	
	pu ,		Usual Residence of	Decedent 10b. County			100 0	ity, Town or I	acation							0d. Inside City Limits
	shov	2	10a. State						ocation						,	1 ☐ Yes 2 🙀 No
	8a-1	ecto	MD	Howard	1		COT	<i>m</i> bia	104.7:-	Codo				10a Citizon	of Mhot Cour	
	a or 2	Funeral Director	10e. Street and Num		D	.1. 70.		0.1	10f. Zip		1.4			10g. Citizen of What Country?  USA		
	s 23	era.	5235 W.	Running			ont Ever in t		Was Dece	2104		nin? (Sne	acify Yes or No-		Race - Americ	an Indian
	item item	'n	11. Marital Status 1 ☐ Never Marrie	ad 21 <b>3</b> Marrie	An	med Force	s?	,	If Yes, spe	cify Cuba	n, Mexican	, Puerto	ecify Yes or No- Rican, etc.)	8	Black, White,	
336	urs al	þ	3 ☐ Widowed		If Ye	Yes 2 Yes, Give Par or Date	A.		1 🗆 Yes	2 <b>∑</b> №	Specify:			Spe	cify: W	hite
ğ	within 72 hours after death with the Maryland ene. than "natural", or items 23s or 28s-f show tha Musical Expusition is that be mailfied at	ted	(0	15. Decedent's fy only highest	Education	n (atad)			edent's Usu			of worki	ina	16b. Kind of	Business/In	dustry
2	thin 7	ple	Elementary/Secon			llege (1-4	or 5+)	life.	DO NOT u	se retired	1)	O WOIN	,,,9			
2	ed wi	Completed by	12					St	eel W	orkei					ehem S	teel
P	tal Hydrand doub	Be	17. Father's Name (		ist)								(First, Middle,			
<u>X</u>	ould Men Marke Marke	ို	Charles					405 11.		(2)			herine I			Codel
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23s or 28s-1 show any fnjury or other traumatic event, the Medical Expuriment must be notified at once.		19a. Informant's Na Fred Ludy		son	nnt)							al Route Numbe Columb			
	1 and Healt em 2 ther		20a. Method of Disp			,	20b.	Place of Disp	position (Na	ne of			Date		n - City or To	own, State
Baltimore,	ages nt of t: if it		1X Burial 2	Cremation :		al from Sta	ate Mo	cemetery, cr				4/2	7/2005	Elkri	dge, M	D
를	artme artme ortan injury		* 4 ☐ Donation 21. Signature of Fur				ric									dge MP, Inc.
Ba	Depar Impo any fr		M	K. 1	tel	w	10~	\ 7	ary L 250 W	• Kai	arman	Blv	erai Hor d., Elki	ne e me cidae.	MD 2	age MP, Inc. 1075
			23a. Part1. Enter th	e disease, or o	omplication	s that cau	sed the dea									Approximate Interval Between
	Physician		Immediate Cause (I		ny one cau	KT	7 S T	7	R1	2-11	1	10	ncer			Onset and Death
}	/Medical		disease or condition resulting in death)	'	r a	Due to (or	as a conse			Ma	COLV	Lu	ncer			/ 11
r	Examiner		Commentally list son	adision o	b											6 months
H.	D =	ner	Sequentially list con if any, leading to im cause. Enter Under Cause (Disease or i	mediate riving		Due to (or	as a conse	quence of):								
	ocute nd trans	Examiner	Cause (Disease or i that initiated events resulting in death) L		c											
8760,	ate be executed thysician and the burial-transit		resulting in deality a			Due to (or	as a conse	quence of):								
	cate b	Physician/Medical		,	d											
9 x	death certifica e attending ph of for use as th	/Me	IF FEMALE:		23c. lf	ves. outco	me of pregi	nancy						224	Date of delive	20/
Вох	atten for u	ian	23b. Was decedent in the past 12	months?	1(	Live birt	n 2 ☐ Fe	al death 3	☐Ectopic p		,				Month	Day Year
P.O.	0 0 0	isio	1 □ Yes 23€ 9 □ Unknown	₽No		Unknow										
	requires that the leen signed by th hould be detache		Part II. Other signifi	cent condition	s contribut	ing to deat	th but not re	sulting in the	underlying o	ause giv	en in Part I.		23e. Did to	bacco use c	ontribute to th	ne cause of death?
rds	urres n sign	d by											1 □ Y	es 2□No	3 Prob	pably 4 Dinknown
00	> 17 0	ojet											24a. Was		b. Were auto	psy findings available mpletion of cause of
Vital Records,	9 4 9	Completed											autop perfor 1 Yes	med? 2 No	death?	2. No
ta	ician: Th certificate rector, pag	O	25. Was case referr	red to medical							26. Place	of Death	h (Check only o	10		7
	S Si D	ToB	examiner?	No	Hospit	al: 1 🗌 Inp	atient 2[	☐ ER/Outpati	ent 3 D	Oth Oth	er: 4 🗆 Nu	rsing Ho	me 5 Resid	ence 6 🗆	Other (Specif	y)
n of	ding Ph J. After th funeral		27. Manner of Death	n 5 ☐ Pending	28	a. Date of (Month,	Injury Day Year)	28b. Time Injury		28c. Injury Wor			28d. Describe h	ow injury oc	curred	
sio	Attending r death.	cati	2 ☐ Accident 3 ☐ Suicide	investiga 6 ☐ Could no	at be				М	1 🗆	Yes 2		00( 1 // //-			10
Division	il or Attendate after death Director:	Certification:	4 Homicide	determin		e. Place of building	njury - At , etc. (Spec	home, farm, : ify)	street, factor	y, office			City or Tow		mber or Hura	al Route Number,
	Hospital		29a. Certifier	15 2 artifying	Physician	. To the h	est of my ki	ah anhalwa	ath occurred	at the tin	ne date an	d place	and due to the o	rause(s) and	manner as s	tated
	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the funer	edicai		2 Medical E	xeminer: (	on the bas	is of examin	ation and/or	investigation	ı, in my o	pinion, dea	th occurr	red at the time, o	date and place	ce, and due to	the cause(s)
	To the within 2 To the complet	Me	29b. Signature and	Tive of certifier					29	c. Licens	e number		^	29d. Date sig	ned (Month,	Day, Year)
	1	/	1/AX	10		M	7		1	000	202	2	/-	pril	25,2	2005
1	07		COD.	ess of person v	no comple	ted cause	of death (Ite	om 23a) (Typ	e. Print)	n	/	1		1	,	12
-[	V		RAJIV	42	a, W	D.	1101	OLD	Anna	poti	s Rol	,56	Li cott.	= ity, t	10.210	12
	Sta		31. Date filed (Mont		2005	32 Reg	ıstrar's Sigi	A A	2006	, .				/		
	- Regist	rair	F	APR 2 7	7007	JUBI		-/								

State of Maryland / Department of Health and Mental Hygiene State Registra Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Yea **Physician** MILSTEIN BERNICE LEVIN APRIL 22 2005 11:07 A /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** SUNRISE ASSISTED LIVING-PIKESVILLE PIKESVILLE BALTIMORE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 04/22/1921 Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□M 2**X**F Days Months Hours 84 212-12-2240 Yrs. MD Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10h County 10d. Inside City Limits or 28a-1 show 1 ☐ Yes 2 ☑ No MD BALTIMORE Directo BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3800 OLD COURT ROAD 21208 U.S.A. items 23a Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. I mortent: If item 27 is marked other then "netural", or Item any injury or other freumatic event, the Medical Excelled once. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify: Specify: WHITE 3 N Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed, Elementary/Secondary (0-12) College (1-4or 5+) HOUSEWIFE OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be SAMUEL MILSTEIN ANNA SCHWEITZER 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ANNE BERMAN / DAUGHTER 2413 VELVET RIDGE DRIVE OWINGS MILLS, MD 21117 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State BETL EL MEMORIAL PARK¦04/26/2005 RANDALLSTOWN, MD \* 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licensee 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine or Attending Physicien: The law requires that the death certiticate be executed use as the burial-transit and Due to (or as a consequence of): P.O. Box 68760, the attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part L 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, by 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 22 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 X Other (Specify) LIVING Certification: To 1 Tyes 2.75No 1 Inpatient 2 ER/Outpatient 3 DOA filled in by the tuneral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Accident 5 Pending investigation 1 Yes 2 No Director 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide within 24 hours a To the Funerel C 29a. Certifier 14 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number ပ April 22, 2002 30. Name and address of person who comple d cause of death (Item 23a) (Type, Print) Main 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death April 17, Day 2005 Year Physician Evelia March 12:30 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 217 Booth Street #218 Gaithersburg Montgomery | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Oct | 5, 1947 5. Social Security Number 9. Birthplace (State or Foreign Cuba) 6. Sex 7. Age (In yrs. last birthday) 1 ☐ M 2 🛛 F 231-58-4090 87 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Montgomery Gaithersburg 1 ☐ Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 217 Booth Street #218 20878 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1XYes 2□No Specify: cuban white ģ Specify: 3 □ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) professor college 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Raimundo Martinez de Castro Ribas y Bermudez 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eduardo March/son 7000 Cashell Manor Court Derwood, MD 20855 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4X Donation 5 ☐ Other (Specify) 21. Signature of Forneral Service Licensee Ronald S. Wade, 32 Name and Address of Facility Board 655 W. Baltimore Street Director evices Baltimore, MD 21201
the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part Enter the disease, or comblications that caused the shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) PANCREATIC MONTH Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 XNo 3 Probably 4 Unknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 📉 No Certification; To 1 Inpatient 2 EN/Outpatient 3 DOA 27. Manner of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 T Homicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29b. Signature and little of certifier. 29c. License number 29d. Date signed (Month, Day, Year) D0061083 APRIL 21,2005

The law requires that the death certificate be executed attending physicien Division of Vital Records, P.O. Box 68760, the been signed by the should be detach page 2 certificate Director: After this within 24 hours a To the Funerel I

**Funeral** 

Director

r teme 23s or 28s-f show

0

If is marked other than "natural", o traumatic event, the Madeal Exer-

permit. Peges 1 and 2 should be it Department of Health and Mental F Important: If item 27 is marked of any injury or other traumatic even 9008.

**Physician** 

**Examiner** 

/Medical

Peges 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

Baltimore, Maryland 21215-0036

State Registrar 31. Date filed (Month, Day, Year) APR 2 7 2005

M. Thambi

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ciclithersburg 32. Registrar's Signature

MD

			For State Registrar	State	of Maryland		artment			ind M		giene Rag. No.	005	1428	0
0 .			Decedent's Name (First, Middle, Last)									ath		3. Time of D	eath
	sicia edic		Susan C.	Mandervi:	11e						Month April	Day 20	2005	4:52A	М
	eaic imin		4a. Facility Name (If not institution,				4b. City, 7	Town, or	Location of	f Death	IIPI II		ounty of Dea		
			Carroll Hospit	al Cente:	ŗ		Wes	tmin	ster			C	arrol1		
Fune			5. Social Security Number	6. Sex 1 ☐ M 2 🖫 F	7. Age (In yrs. last		If Under Months	1 Year Days	If Under 2 Hours	24 Hrs. Min.	8. Date of Birtl (Month, Day	v, Year)	Co	thplece (State or I	Foreign
Direc	tor	-	Usual Residence of Decedent		55	Yrs.					Dec. 2	5,194	9	MD	
laryland show	4	1	10a. State 10b. County		10c. City, T	own or Lo	cation							10d. Inside City	Limits
Man 1-1 sh		ţō	MD Bal	timore	R	eiste	rstow	n						1 ☐ Yes 2	No 🏋
ith the M or 28a-1		10e. Street and Number 10f. Zip Code										10g. Citize	n of What Co	ountry?	
th wil												U	SA		
er dee		Funerai	11. Marital Status	Armed F	cedent Ever in U.S. orces?	13.	Was Deced	ent of His	spanic Orig	in? (Spe Puerto I	cify Yes or No- lican, etc.)	14	Race - Ame		
s effe		by Fu	1 ☐ Never Married 2X Marri 3 ☐ Widowed 4 ☐ Divorced	If Yes, G			1□Yes 2		Specify:				pecify:		
filed within 72 hours efter deeth with the Maryland Hygiene. Hygiene "naturel", or items 23a or 28a-f show			15. Decedent	Year or I	2,00	6a Dece	dent's Usua	I Occupa	ition				WI of Business	nite	
In 72	The second	piet	(Specify only highes	t grade completed,	)	(Give	kind of won DO NOT us	k done di e retired)	uring most	of workir	ng	TOD, KING	or business	rindustry	
d with		Completed	Elementary/Secondary (0-12)	College	(1-4or 5+)		Hous	ewif	e			0	wn Hom	ie	
of file	Yan Y	Bec	17. Father's Name (First, Middle, I	ast)					18. Mother	r's Name	(First, Middle,	Maiden S	итате)		
2 should be and Mental ie markad o		P -	Harry E. Snyd	er					Fr	ieda	Albar	n			
			19a. Informant's Name/Relationsh	ip (Type, Print)	Husband	19b. Mailir	ng Address	(Street a	nd Numbe	r or Rura	Route Numbe	r, City or T	Town, State, 2	Zip Code)	
and land seelth	Day I		Bernard P. Mand	erville,		11 A	ustin	Roa	d, Re		rstown,		21136		
Pages Inent of H	5		20a. Method of Disposition 1 ☐ Burial 2 ∑ Cremation		000	etery, crer	natory or ot	e or her place	9)		ate	20c. Loca	tion - City or	Town, State	
it. Pa	du .		'4 □ Donation 5 □ Other (Sp. 21. Signature 1 = neral Service L		Carı	4	Crema			/23/			pstead		
Depart The Control	any ii		21. Signature 1 entieral Service (	.ICertisee			. Name and							wn Road	
OH!			23a. Part1. Enter the disease, or	complications that	caused the death. [		line er the mode				Reiste		wn, MD	Approximate	
Dhusis		-	Immediate Cause (Final	only one cause on	each line.	1	11	n =	,		,,			Interval Betwe Onset and De	
Physic /Medi	_		disease or condition resulting in death)	a	(or as a consequen	oce ot).	Clo.	V						year	
Examir	ner				(0. 40 4 00.100420.1	.00 017.									
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to	(or as a consequen	ice of):								-	-
cuted	200	Examiner	Cause (Disease or injury that initiated events	С											
ate be executed hysician and			resulting in death) Last	Due to	(or as a consequen	ice of):									
ate ate	9	dicai		d											
The faw requires that the death certification is been signed by the attending phase of the control of the contr	000	Physician/Me	IF FEMALE:	23c. If yes, or	itcome of pregnancy	,									
eath atten	0	cian	23b. Was decedent pregnant in the past 12 months?	1 Live	birth 2 Fetal de	ath 3	Ectopic pre					23	<ul> <li>Date of del Month</li> </ul>	Day Yea	ar
the d	De la	ysi	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	9☐ Unkr			J Outor (Spe	,c.i.y/							
res that the de	000	by PI	Part II. Other significant conditio	ns contributing to	death but not resultin	ng in the u	nderlying ca	use give	n in Part I.		23e. Did to	bacco use	contribute to	the cause of dea	ith?
w require been sig	2	ed L	(hrmic Obst	welve !	ulmman	1)150	all				1 🗆 Y	es 2 🗆	No 3□Pr	obably 4 20nk	<nown< td=""></nown<>
aw re	200	piet	Thoracic Soil	re Como	ressim.	FRI	hre				24a. Was a		24b. Were au	topsy findings ava	ailable
The t	Page Carde	Completed		1		•	· · · · · · · · · · · · · · · · · · ·				autop: perfor		death?	completion of cau: 2 ☐ No	se of
Physician: The lav	Clor.	Bec	25. Was case referred to medical examiner?						26. Place	of Death	(Check only or				
hysic his ce	5	2	1 ☐ Yes 2 Z No			/Outpatien	t 3 DO	Othe	r: 4 ☐ Nur	sing Hom	e 5 Resid	ence 6[	Other (Spec	cify)	
ing P	nuela	on:	27. Manner of Death 1 ■ Natural 5 ■ Pending		of Injury oth, Day Year)	b. Time of Injury		Bc. Injury Work	?		8d. Describe h	ow injury o	occurred		
ttand death stor:	all	icat	2 Accident investig 3 Suicide 6 Could n	ot be			М		'es 2□N		24 11 (2				
or A or A efter Dirac	la by	Certification	4 ☐ Homicide determi	ned 286. Plac	e of Injury - At home fing, etc. (Specify)	, tarm, str	eet, tactory,	office		2	City or Tow	treet and t n, State)	Number or Ru	ural Route Numbe	۲,
spital ours naral			29a. Certifier 1 Certifying	Physician: To th	e best of my knowle	dge death	occurred a	t the time	e date and	I place, a	nd due to the c	21150(5) 25	nd manner as	etated	
To the Hospital or Attanding Physician: within 24 hours effer death.	letely	edicai	(Check only 2 Medical E	xaminer: On the l	pasis of examination nner stated.	and/or in	vestigation,	in my op	inion, death	n occurre	d at the time, d	date and pl	ace, and due	to the cause(s)	
To the To the		ž	29b. Signature and title of certifier	11/1			29c.	License	number		2	29d. Date s	signed (Monti	h, Day, Year)	
			<b>•</b>	1000	mil			)33	184			Honil	20,	2005	
(10)			30. Name and address of person	who completed cau	110	4 2	chair	s (.	ente	- Do	ihe R	exter	stown.	MOZII	36
Red	Stat gistra		31. Date filed (Month, Day, Year)  APR 2. 7		Registrar's Signature	-	whi			1		11.10	1	711	
			nin a i	2000		-									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** McClernan Pau1 Joseph April 27, 2005 7:49 a /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Westminster Carroll 226 Montpelier Court 7. Age (In yrs. last birthday) If Under 1 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Months 1 ★M 2 ☐ F Yrs. May 26, 1937 Pennsylvania Director 216-34-4352 Usual Residence of Decedent 10c. City, Town or Location 10d, Inside City Limits 10b. County 10a. State 28a-f show treumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2X No Director Baltimore Windsor Mill 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ъ 21244 U.S.A. Items 23a 7140 Fairbrook Road death Completed by Funeral permit. Pages 1 and 2 should be filed within 72 hours after deal Department of Health and Mental Hygiene. Importent: If Item 27 is marked other there? only injury or other treum... Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 Never Married 2 Married XYes 2 □ No 1 ☐ Yes 2 ☑ No Specify: If Yes, Give Year or Dates: Specify: 3 ☑ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Social Security Adm. Programmer 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be McClernan Florence K. Long Frank 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2 Wild Cherry Court Reisterstown, MD Brian K. McClernan Son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) Carroll Cremation Ser 5/2/05 Hampstead, MD 22. Name and Address of Facility 21. Signature of Euneral Service Licensee 11824 Reisterstown Road 520 Eline Funeral Home Reisterstown, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Meta Static Prostate Green Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as e consequence of) Examiner The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): Box 68760, Physician/Medicai IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Day Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No ō 4□Pregnant at time of death 5 Other (specify) P.O. the 9 Unknown à 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes Records, Be Completed by 1) Covers 2 No 3 Probably 4 Unknown cate has been sig 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Now rme**ù**? 2**∐**No & Melanoma 1 Tyes 1 🗌 Yes certificate Division of Vital Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) WIECES Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To RESIDENCE his 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No М 2 Accident Director: 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 | Homicide within 24 hours a To the Funerel D 1 (A Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 0 937035 70 27, 2005

Registrar

State

30. Name and address of person who completed cause of death (Item 23a) (Type (Rrint) dallstown, Tany (aw)

32. egistrar's Signatur

2005

#### e.

Please Type or Print in Black Indelible Ink.	. Ensure All Copies Are Legible
01-1	

ELL J. M	ΊΙΤΖ	ZEL For Stata Registrar	State of Marylar		artmen <i>rtificat</i>				_	giene Rag. No.	2005	1428
Physic	ian	1. Decedent's Name (First, Middle, Last)						2	2. Date of De Month		Year	3. Time of Death
/Medi	cal	Russell James  4a. Facility Name (If not institution, give st	Mitzel		4h Cih	Tours	Location of		APRIL		2005 County of Dea	1400 P
Exami	ner	2528 WHITEFORD R	OAD		WHI	TEFC	RD			ŀ	IARFORI	)
Funeral Director		5. Social Security Number  211–26–7024  Usual Residence of Decedent	7. Age (In yrs.	Yrs.	If Under Months	Days	If Under Hours	Min.	B. Date of Bir (Month, Da 18. 1,	iy, Year) 1935	C	rthplace (State or Forei ountry) CNOWN
the Maryland 28a-f show	ector	10a. State 10b. County  Maryland Harford  10e. Street and Number	10c. C	White		Code				10a Citiz	ron of Minat C	10d. Inside City Limi
3a or	Ö	2528 Whiteford Road	d		101. 210	0000				10g. Citizen of What Country? United States		
ite; Marylatin ZIZIS-0030 s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. If Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23s or 28s-f show other treumetic avent, the Medical Examinar must be mutified at	by Funeral Director		2. Was Decedent Ever in U Armed Forces? 1 ∐ Yes 2 M No If Yes, Give Year or Dates:		Was Deced If Yes, spec	ify Cuba	spanic Ori n, Mexicar Specify:	, Puerto Ri	fy Yes or No can, etc.)			erican Indian, te, etc.
A I A I D-0000 of within 72 hours at glene. I than "natural", or I the Medical Exami	Completed	15. Decedent's Educe (Specify only highest grade Elementary/Secondary (0-12)	ation completed) College (1-4or 5+)	16a. Dece (Give life.	kind of wo DO NOT us	rk done d se retired,	ition luring mos )	t of working	1	16b. Kin	nd of Business	,
and AIA	Be	12 17. Father's Name (First, Middle, Last) unk			Unkno	OWN	18. Mothe		First, Middle,	, Maiden S	Unknov Sumame)	wn
INCAL VICELION  d 2 should be file th and Mental Hy 77 is marked oth treumetic avant	To	19a. Informant's Name/Relationship (Type	•		5232					297 3	Town, State,	Zip Code)
Pages 1 and nent of Health out: If item 27 iry or othar tr		Carol Keiser, Daugl  20a. Method of Disposition  1 □ Burial 2 X Cremation 3 □ Re	20b.	Place of Dispo cemetery, crer	sition (Nam natory or o	ne of ther place	9)	Dat		20c. Loc	ation - City or	
permit. Pages 1 and 2 s permit. Pages 1 and 2 s Department of Health ar Importent: If item 27 is any injury or other treu once.		' 4 □ Donation 5 □ Other (Specify)  21. Signature of Fund 1 projection for the projection of the proj			2. Name an	d Addres	s of Facilit	y Tim	thy S.	Harrie	dale, Ma n urnie, M	
_ 22_44		23a. Part1. Enter the disease, or complic shock, or heart failure. List only one	ations that caused the dea								uine, r	Approximate Interval Between
Physician // Medical be executed but it is a physician and but in the but in	dicai Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  d.	Due to (or as a consect  Due to (or as a consect  Due to (or as a consect	quence of):	CARC	ARCINOMA						
the death certify the attending ched for use a	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of a 9 ☐ Unknown	al death 3	Ectopic pr Other (sp					23	3d. Date of de Month	livery Day Year
quires that in signed by ald be deta	by	Part II. Other significant conditions cont	ributing to death but not re	sulting in the u	nderlying c	ause give	n in Part I.		1	obacco us Yes 2 🗆		o the cause of death?
	Completed										24b. Were an prior to death?	utopsy findings availab completion of cause of
Physician: The Physician: The Physician The Physician The Physician The Physician The Physician	To Be	25. Was case referred to medical examiner?  Yayes 2 No	spital: 1 Inpatient 2	ER/Outpatier	ıt 3□ DC	Othe	r		Check only o		X)Other (Spe	cify) AT SCEN
tanding Ph leath. tor: After th		27. Manner of Death 1 Matural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	M 2	28c. Injury at Work? 28d. Describe how injury				how injury	occurred	
To the Hospital or Attanding within 24 hours after death. To tha Funerat Director: After completely filled in by the fune.	Certification:	3 Suicide 6 Could not be 4 Homicide determined					et, factory, office 28f. Location (Stree City or Town, S			Street and vn, State)	Number or R	ural Route Number,
To the Hospital or At within 24 hours after or To tha Funerat Direct completely filled in by	Medicai	29a. Certifier (Check only one)  1 Certifying Physical Examine	cian: To the best of my know: On the basis of examination and manner stated.	owledge, death ation and/or in	occurred vestigation,	at the tim in my op	e, date and inion, dea	d place, and th occurred	d due to the at the time,	cause(s) a date and p	and manner as place, and due	s stated. e to the cause(s)
To th withir To th comp	Me	29b. Signature and title of certifier				. License	number				signed (Mont	
		> aness			(	OCME				AP	RIL 19	, 2005
		30. Name and address of person who com  AMA RWG ( 31. Date filed (Month, Day, Year)	o , mo			111 1	Penn	Stree	t Bal	timo	re, Mai	ryland 2120
St Regist	ate rar	APR 2 7 2005	Medica &	ature	K							

			1 - For State of Maryland / Registrer		rtment of Hetificate of L			ene (	3	4283
	Physici /Medio		1. Decedent's Name (First, Middle, Last)  MARIE K. MEAGHER				2. Date of Death Month APRIL 21	Day 2005	Year	3. Time of Death 4:00 P M
ž	Examir		4a. Facility Name (If not institution, give street and number)  Baywoods of Annapolis  5. Social Security Number 6. Sex 7. Age (In yrs. last b	inthday)	4b. City, Town, or  Anna  If Under 1 Year	polis	8 Date of Birth	4c. County Anne	Arun	
	Funeral Director		018-16-4561 1□M 2ĀF 85  Usual Residence of Decedent	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, ) 5-6-191	9	Massa	lace (State or Foreign htry) achusetts
	laryland show	).	10a. State 10b. County 10c. City, Tou						1	0d. Inside City Limits 1 ☐ Yes 2X No
	the M	rect	Maryland Anne Arundel Lo	othia	10f. Zip Code		100	g. Citizen of V	What Coun	
	th with	al Di	1122 Pemberton Lane		2071	1		USA		
036	nit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland artment of Health and Mental Hyglene. ortent: If item 27 is marked other than "natural", or Itams 23e or 28e-f show injury or other traumatic event. I're Modical Exerting must be notified at 6e.	by Funeral Director	11. Marital Status  1 Never Married 2 Married  X Was Decedent Ever in U.S. Armed Forces?  1 Yes 2 No If Yes, Give Year or Dates:		Vas Decedent of His Yes, specify Cubar ☐ Yes 2 No	spanic Origin? (Spec n, Mexican, Puerto F Specify:	pecify Yes or No- o Rican, etc.)  14. Race - American Indian Black, White, etc.  Specify: White			etc.
21215-0036	vithin 72 ho ne. han "natur e Modical	Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  Commercial Artist				16b. Kind of Business/Industry		dustry
2	Hygier Hygier Ther ti nt, In	CO	2 years C	Comme		tist 18. Mother's Name		Art	20)	
auc	should be and Mental I markad o	To Be	Joseph Aloyisius Kirby			Mary			16)	
Maryland	2 should be filed withir and Mental Hygiene. Is marked other than aumatic event, Ire M.	-	19a. Informant's Name/Relationship (Type, Print)	b. Mailing	g Address (Street a	nd Number or Rural	Route Number, C	City or Town,	State, Zip	Code)
	and 2 ealth m 27 I		Stephen T. Meagher/ Son	1122	Pemberto	on Lane, I				
Baltimore,	permit. Pages 1 and 2 Department of Health a Importent: If item 27 It any injury or other tra 90029.		1   Burial 2 □ Cremation 3 □ Removal from State cemeter  cemeter	ery, crem	ition (Name of atory or other place	•)		c. Location -		
Ē	artmer artmer ortent injury		'4 Donation 5 □Other (Specify) Arlin  21. Signatur Funeral Service Licensee	ngton	Natl. Ce	em. 6-22- s of Facility GEO	-05 RGE P. K	Arling ALAS F	ton,	Virginia L HOME
B	Depar Impor any ir		* Kontillede-	29	73 SOLOM	ONS ISLAN	D ROAD,	EDGEWA	TER,	MD.21037
	Physician /Medical Examiner		23a. Part1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. Due to (or as a consequence)	, such as cardiac or	respiratory arres	t,	/	Approximate Interval Between Onset and Death		
68760,	ificate be executed g physician and as the burial-transit	edicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b. Due to (or as a consequence cause.)  Due to (or as a consequence cause.)							
.O. Box	The law requires that the death certific tte has been signed by the attending pl page 2 should be detached for use as	Completed by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown		Ectopic pregnancy Other (specify)			23d. Dat	e of delive	ry Day Year
S, D	iw requires that s been signed b s should be deta	ed by PI	Part II Other significant conditions contributing to death but not resulting	in the un	derlying cause give	n in Part I.	23e. Did toba			e cause of death?
Vital Record		Complet	<i>'</i>				24a. Was an autopsy performe	d?	prior to con leath?	osy findings available apletion of cause of
Ĭ,	Physician: Th this certificate ral director, pag	Be c	25. Was case referred to medical examiner?  1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ FB/O		2√ DOA Other	26. Place of Death				
o	g Physer this eral di	n: To	27. Manner of Death 28a. Date of Injury 28b.	Time of	28c. Injury	at 28	Bd. Describe how			)
sion	ttending I death. stor: After	atio	2 Accident investigation	Injury	M 1 Y	es 2 □No				
Division of	al or Attences after death	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury · At home, f building, etc. (Specify)	farm, stre	et, factory, office	25	Bf. Location (Stree City or Town, S	et and Numbe State)	er or Rurai	Route Number,
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical (	29a. Certifier (Check only one)  1 Certifying Physicien: To the best of my knowledg 2 Medicel Examiner: On the basis of examination as and manner stated.	ge, death ind/or inve	occurred at the time estigation, in my opi	e, date and place, ar inion, death occurred	nd due to the caus d at the time, date	se(s) and ma and place, a	nner as stand due to	ated. the cause(s)
	To the within 2 To tha complet	Σ	29b. Signature and title of capitie		29c. License	number	29d	. Date signed	(Month, L	Day, Year)
,	10		30. Name and address of person who completed cause of death (Item 23a)	) (Type, P	1 5 5 (rint)	128	4	124	05	
	Sta		31. Date fled Month, pay, Year 32 (Segistrar's Signature APR 2 7 2005)	A	nepoles	Kood	#106	oder	Ton	MD21113
	Registr	aı	- 1 COOS CONTRACTOR	MA						

Linda Sharon Murphy Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 05-02866 R.J State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) Day Year **Physician** Murphy Linda Sharon 24, 2005 4c. County of Death April 08:48 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** <u>Baltimore</u> 44 Parkhill Place Perry Hall 8. Date of Birth (Month, Day, Year) If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday, 5. Social Security Number **Funeral** Days Hours 1 M 2 F 53 Yrs. 13 1951 Director Maryland 214-58-7911 Usual Residence of Decedent the Maryland 10c. City. Town or Location 10d. Inside City Limits 10b. County 10a State 28a-f show other traumatic evant. The Medical Examener must be notified at 1 ☐ Yes 2 ☐ No Director Perry Hall Maryland Baltimore 10g. Citizen of What Country? 10f Zin Code 10e. Street and Number ŏ items 23a 21236 U.S.A. 44 Parkhill Place Completed by Funeral Pages 1 and 2 should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status ☐Yes 2☐No fYes, Give 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Baltimore, Maryland 21215-0036 ō Specify: 3 ☐ Widowed 4 1 Divorced White "natural" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Doctors Office NA Receptionist 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be is marked of Tomczewski Murphy Regina 2 Eugene 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Deportment of Health a Important: if item 27 is any injury or other traignes. Regina Griffin ( Mother ) 9416 Dawnvale Road Baltimore, Maryland 21236 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition AprilDate 29, 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 2005 Dundalk, Maryland \* 4 ☐ Donation 5 ☐ Other (Specify) Holy Rosary <sup>22</sup> Name and Address of Facility. W. Dabrowski/Chojnacki Funeral Homes P.A. 21. Signature of Funeral Service Licensee 1005 Dundalk Ave. Baltimore. Marvland. 21224 on 23a. Part1. Enter the disease, or complications at caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cay e on each line. Approximate Interval Between Onset and Death uportensive atheres tensticadions endis Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause, [Disease of injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner The law requires that the death certificate be executed burial-transi Due to (or as a consequence of): Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) P.0. the 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. δ Unknown 1 ☐ Yes 2 ☐ No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 2 🗆 No 1 Yes Yes 2 No Hospital or Attanding Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other:  $_{4\square \, \text{Nursing Home}}$  5  $\square \, \text{Residence}$  6XXQther (Specify)  $At \, \, \text{scene}$ 1 ¥ Yes 1 Inpatient 2 ER/Outpatient 3 DOA 2 🗀 No 0 this 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death Certification: After 5 Pending investigation 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No death. Diractor: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 🗌 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Medical To the within 2

29a. Certifier

29b. Signa

ame and address of person who completed cause of 32. Registrar Signature 31. Date filed (Month, Day, Year)

OCME April 25, 2005

Penn Street Baltimore, Maryland 21201

29d. Date signed (Month, Day, Year)

Registrar

29c. License numbe

		1 - For State Registrar	State of Ma	ryland / Dep <i>Ce</i>	artment of ertificate of		-	giene	11005			
Physic		1. Decedent's Name (First, Middle, La Leila	Mae McDan	iel			2. Date of De	26, 2005 Year	4:29 pm M			
/Medi Exami		4a. Facility Name (If not institution, given 302 Fa11 Lane	ve street and number)		4b. City, Town,	or Location of Dea	ath	4c. County of Death Talbot				
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Annual Point Number 216–28–7606 1 M 2 F 83 Yrs. Social Security Number 2 If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Min. Min. March 29, 1922 1 M Narch										
Maryland f show	tor	10a. State	t	10c. City, Town or L Easton	ocation				10d. Inside City Limits 1 □ Yes 2 X No			
h with the	Funeral Director	10e. Street and Number 302 Fall Lane			10f. Zip Code	601		10g. Citizen of What Cou	ntry?			
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other treumatic event, the Modical Examinar quest pages.	þ	11. Marital Status  1 Never Married 2 Married 3 M Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☐ N If Yes, Give X Year or Dates:	Ever in U.S. 13.	Was Decedent of If Yes, specify Cu		Specify Yes or No irto Rican, etc.)	Sanaihu.				
Baltimore, Maryland 21215-0036 bermit. Pages 1 and 2 should be filed within 72 hours alt Department of Health and Mental Hygiene. In them 27 is marked other than "natural", or my highry or other treumatic event, the Modest Examing highs on the presentations.	Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)	ducation rade completed) College (1-4or 5-	+) (Giv	edent's Usual Occ e kind of work don DO NOT use retii memaker	upation e during most of w red)	orking	16b. Kind of Business/Ir				
/land 2 wid be filed Mental Hygi arked other	To Be Co	17. Father's Name (First, Middle, Las John Blanto	•				ame (First, Middle, tha Stew	Maiden Sumame)				
S, Mary and 2 sho tealth and I m 27 is me		19a. Informant's Name/Relationship  Mrs. Caroline M.		ughter) 3	02 Fall 1		on, MD 2		· · · · · · · · · · · · · · · · · · ·			
timore t. Pages 1 riment of H rient: If Ite		20a. Method of Disposition  1	ify)	Seal Fam	ily Ceme	tery 4/2		Sunshine, N	<b>1</b> D			
Bal Permi Depar Impol		21. Signature of Foneral Service Lice  23a. Part 1. Enter the disease, or conshock, or heart failure. List only	1 1 ~/	7-	Haight Fi Sykesvil	ress of Facility uneral Ho le, MD 21	ome & Cha 784 (410	pel, PA (Box				
Physician /Medical Examiner	١	disease or condition resulting in death)	a	a consequence of):		e Dov		rrest,	Approximate Interval Between Onset and Death			
8760, sate be executed physician and the burial-transit	Physician/Medical Examiner	Sequentially list conditions, if any, leading to immediate auss first underlying Cause (Disease or injury that initiated events resulting in death) Last	c	a consequence of):								
.O. Box 6 the death certification by the attending p	hysician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of the control	2 Fetal death 3	□Ectopic pregnan			23d. Date of deliv Month	ery Day Year			
cords, P w requires that been signed to should be deter	þ	Part II. Other significant conditions	contributing to death bu	ut not resulting in the	underlying cause o	given in Part I.		obacco use contribute to t res 2 □ No 3 □ Prol				
II Reco The law re ate has ber page 2 sho	Completed						24a. Was autop perfo 1 Yes	osy prior to co	opsy findings available impletion of cause of			
Division of Vital Records, I or Attending Physicien: The law requires the filter cleath. Director: After this certificate has been signed in by the funeral director, page 2 should be do	To Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☑ No  27. Manner of Death	Hospital: 1 Inpatier 28a. Date of Injur (Month, Day	nt 2 ER/Outpatie		Other: 4 🗌 Nursing		dence 6 Other (Special	(y)			
Division of To the Hospital or Attending Ph Within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification;	1 Matural 5 Pending 2 Accident investigation 3 Suicide 6 Could not determined	on De Olean of Iniv	ıry - At home, farm, s	M 1	☐Yes 2☐No	28f. Location (S City or Tox	Street and Number or Run vn, State)	al Route Number,			
Hospita Hospita 4 hours Funerell ely filled	Medical Co	29a. Certifier 1 Certifying P (Check only one) 2 Medical Exa	hysician: To the best of iminer: On the basis of and manner sta	examination and/or i	ith occurred at the investigation, in my	time, date and place opinion, death occ	ce, and due to the curred at the time,	cause(s) and manner as s date and place, and due t	stated. o the cause(s)			
To the I within 2 To the I complete	Ĭ	29b. Signature and title of certifier	The	MO		3/466		29d. Date signed (Month, 4/26/05	Day, Year)			
HA		30. Name and address of person who will be seen address of person who	loeder 1	II.		31466 ston, 1	nd.					
St Regist	ate trar	31. Date filed (Month, Day, Year)	32. Registra	ar's Signature	A STATE OF THE STA	·						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Brad R. McDonald State of Maryland / Department of Health and Mental Hygiene 05-2760 For State Registrar AKG~ Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** April 19, 200<sup>5</sup> 8:55 P M McDonald /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 100 M 2□ F Yrs June 9,1995 Director Mary land 212-45-4452 Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28e-f show the Medical Examiner rest by notified at 1 Yes 2 No Director MD Anne Arundel Harwood the 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 4525 S. Polling House Road 20776 USA items 23a Completed by Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status □Yes 2XNo 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 ō 1 ☐ Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced Year or Dates: "naturel" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b, Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Student Student traumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 2 should be fill and Mental H Be ည Bryan Scott McDonald Gladys Denise Kolbe 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) if Health Bryan S. McDonald (Father) 4525 S. Polling House Rd., Harwood, MD 20776 other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 0 = 0 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Importent: If any injury or once. \* 4 ☐ Donation 5 ☐ Other (Specify) Mt. Zion Church Cem. | 4-22-2005 Lothian, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hardesty Funeral Home, P.A 12 Ridgely Avenue, Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Head miuries disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Completed by Physician/Medical Examiner Due to (or as a consequence of): burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy lor in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.0. detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ▼Yes 2 □ No 24a. Was an page 2 s has 1 X Yes 2 No of Vital Hospitel or Attending Physicien: director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Hospital: 1 ☐ Inpatient 2 ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 1 X Yes 2 □ No 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death Certification: 28d. Describe how injury occurred Division 1 Natural 5 Pending investigation subject was ejected from ATV Fand 19:48 PM death. 2 **X** No 4-19-05 2 Accident Director: 3 🗌 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 C 2 C S Politica House ğ 4 Homicide 45255. Polling House Rd 41019 24 hours Ca Harry d In M D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) To the within 2 and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) hi, April 20, 2005 OCME m.0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LING 111 Penn Street Baltimore, Maryland 21201 min. 31. Date liled (Month, Dav. Year) strar's Signature State 2005 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registranmend item 32 PER DVR G842 4 287166 ate of Death Reg. No. 2 Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2005 Month **Physician** 4:00 AM MAASCH 04 Juy /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** Bart imure HCR Manor Care 509 E Juppa Rd TOWSON If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 9-10-1920 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign **Funeral** 10M 20F Days Hours Min 217-18-907 34 MARYLAND Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits or 28a-f show ed other than "neturel", or items 23e or 28e-f show event, the Medical Exeminer must be notified at 1 ☐ Yes 2 ☐ No MD BALTIMORE TOWSON Directo 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If item 27 is marked other than "---- any nitury or other traumett- any solute. USA 509 JOPPA ROAD 21286 by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

XXYes 2 □ No
If Yes, Give Year or Dates: US ARMY Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. XXNever Married 2 Married 1 ☐ Yes 2 No Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) INVESTOR STOCKS/BONDS 12TH 3 YEARS 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) **EDWARD** MAASCH ANNA MAASCH 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21201 19a. Informant's Name/Relationship (Type, Print) JOHN T. STEWART / GAURDIAN 10 N. CALVERT ST, COMM ON AGING, BALTO, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State `4 □Donation 5XOther (Specify) ENTOMBMENT LORRAINE CEM 4/26/05 BALTIMORE, MD 22. Name and Address of Facility HOWELL FUNERAL HOME 21207 4600 LIBERTY HEIGHTS AVE, BALTIMORE, MD ter the disease, or complications that caused heart failure. List only one cause on each in he death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician or condition resulting in death) /Medical (or as a consequence of) Examiner Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or injury that initiated events The law requires that the deeth certificate be executed use as the burial-transit resulting in death) Last Due to (or as a consequence of) Physician/Medical Box IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 1 Live birth 2 ☐ Fetal death in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) Ö 9 Unknown signed t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, Completed by 2 No 3 Probably 4 Unknown 1 Tyes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an rmed2 2 No 1 ☐ Yes Division of Vital Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? examiner?
1 Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) After thi 27. Mann of Death 1 atural 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide within 24 hours a To tha Funeral I 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Registrar

29b. Signature and title of certifier

Name and address of person who cor

MO

d cause of death (Item 23a) (Type, Print) 32. Registrar's Signature

Pay, Year) 7 2005

COMM C

29c. License number

MO 21204

			amend item#1,pe	e Type or Print in E irMD, G843, 5/13/0 S State of Marylan	Black Indelible Ink. End J-Department of Healt	nsure All Copies th and Mental Hy	s Are Legible. /giene
			1 - State Registrar Amend Item	20b per fh G84	d/Department of Healt 13 Certificate of Dea	ath 5-11-05 tas	Reg. No. UU5 14288
	Physic	an	Decedent's Name (First, Middle, L	Last) Thomas McDar	tiel, Jr	2. Date of D	eath 3. Time of Death Day Year
	/Medi Examir		4a. Facility Name (If not institution, g	give street and number)	4b. City, Town, or Locat	Jr Hpri	4c. County of Death
	Examin	ier	VA Medi	cal Cent	er Baltin	nore	
	Funeral		Social Security Number     6.	. Sex 7. Age (In yrs. 1)	Months Days Hou	nder 24 Hrs. 8. Date of Bi	9. Birthplace (State or Foreign
	Director		Usual Residence of Decedent	74	Yrs.	June	23, 1930 Maryland
	yland how		10a. State 10b. County	10c. Cit	y, Town or Location		10d. Inside City Limits
	the Marylar 28a-f show	ctor	Maryland NI	A	Saltimore		1 X Yes 2 □ No
	€ 9	Directo	10e. Street and Number	1.10	10f. Zip Code		10g. Citizen of What Country?
	lesth w	Funeral	11. Marital Status	12. Was Decedent Ever in U	S. 13. Was Decedent of Hispanic	COrigin? (Specify Yes or N	0- 14. Race · American Indian,
9	after des		1 Never Married 2 Married	Armed Forces?	If Yes, specify Cuban, Mer		Black, White, etc.
5-0036	ural', d	d by	3 ☐ Widowed 4 ☑ Divorced	Year or Dates:	1 ☐ Yes 2 💆 No Spe	ecity:	Specify: Black
15-(	n 72 hours "netural", edical Exe	Completed	15. Decedent's (Specify only highest of		16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired)	most of working	16b. Kind of Business/Industry
2121	l withii iene. r then	omp	Elementary/Secondary (0-12)	College (1-4or 5+)	Lahorer		Private
pu	2 should be filed withir and Mental Hygiene is marked other then eumatic event, the Ma	BeC	17. Father's Name (First, Middle, La	(st) AA		Aother's Name (First, Middle	e, Maiden Surname)
Maryland	should b ind Menta a marked umatic e	To	Ihomas	McDaniel	Sr. E	sther	Gaines
Mar	12 shu n and ris m		19a. Informant's Name/Relationship	(Type, Print) (Friend)	19b. Mailing Address (Street and Nu	umber or Rural Route Numb	per, City or Town, State, Zip Code)
	s 1 and 2 of Health item 27 i		20a. Method of Disposition	Delvison 20b. F	Place of Disposition (Name of )	Aue. Bal	20c. Location - City or Town, State
Baltimore,	00		1 Burial 2 Cremation 3 4 Donation 5 Other (Spe	☐Removal from State	emetery, crematory or other place)	5/2/2005	Duringe Mills Md
ati	permit. Pag Department important: i any injury o		21. Signature of Funeral Service Lice		Lrrison Forest 22. Name, and Address of F	acility =	Olumgs Mills, Max
ä	Depariming on important in impo		aseph	L. Kuss	Joseph L. Ku 2222 W. North	Ss tunera Ave. Balto	Md. 21216
			23a. Party Enter the disease, or co shook, or heart failure. List on	omplications that caused the deat ly one cause on each line.	h. Do not enter the mode of dying, such	h as cardiac or respiratory a	Interval Between
	Ph sician		Immediate Cause (Final disease or condition resulting in death)	_a. Conge	estive heart for	ilure	Onset and Death
	/Medical Examiner		resulting in Geality	Due to (or as a conseq	uence of):		
		Je.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a conseq	uence of):		
	ecuted and i-transit	Examiner	that initiated events	с			
60,	The law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the burial-transit		resulting in death) Last	Due to (or as a conseq	uence of):		
6876	icate b physic s the b	Physician/Medical		d			
9 x	death certificate L attending physic of for use as the b	/Me	IF FEMALE:	23c. If yes, outcome of pregna	Incy		23d. Date of delivery
Вох	death s atter d for u	clar	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live birth 2 Feta 4 Pregnant at time of d	I death 3 Ectopic pregnancy		Month Day Year
P.O.	that the di ed by the detached	hys	9 Unknown	9 Unknown			
	res tha igned be del	<b>by</b> P	Part II. Other significant conditions	s contributing to death but not res	ulting in the underlying cause given in P		tobacco use contribute to the cause of death?
Vital Records,	w require been si should b	ted				1□	Yes 2 No 3 Probably 4 Munknown
3ec	e law has b je 2 sl	Completed				24a. Was	
al			W			1 ☐ Yes	2 <b>Z</b> ,No 1 ☐ Yes 2 ☐ No
Z:	ysicien: nis certifica director, p	To Be	25. Was case referred to medical examiner?  1 Yes 2 No	Hospital: 1 Inpatient 2	0.0	Place of Death Check onl	one idence 6 □Other (Specify)
Division of	2 = 4		27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of 28c. Injury at		how injury occurred
jo	utending R death. ctor: After y the funer	Certification;	1 Natural 5 ☐ Pending investigat	tion	Injury Work? M 1 ☐ Yes 2	2 🗆 No	
Ϋ́	i or Atten after deatl Director; I in by the	rtific	3 Suicide 6 Could not determine	t be ed 28e. Place of Injury - At he building, etc. (Specif	ome, farm, street, factory, office	28f. Location ( City or To	(Street and Number or Rural Route Number, wn, State)
Ω			200 Cartifier 17 Cartifular	Dhusiaine Taka baat of multiple	udada daab aa aa aa aa aa aa aa aa aa aa aa aa	1	
	To the Hospitel or All within 24 hours after or To the Funerel Direct of Impletely filled in by	Medical	29a. Certifier 1 Certifying (Check only one)	Physician: To the best of my kno aminer: On the basis of examina and manner stated.	wiedge, death occurred at the time, date tion and/or investigation, in my opinion,	e and place, and due to the death occurred at the time,	cause(s) and manner as stated. , date and place, and due to the cause(s)
	To the within 2 To the Complet	Me	29b. Signature and title of certifier		29c. License numb	Der	29d. Date signed (Month, Day, Year)
)	1/		Ilian bro	undaranash	MD P185	73	April 21 2005
-	51		30. Name and address of person wh	20			A 12 11 12 12 12 12 12 12 12 12 12 12 12
-			31. Date filed (Month, Day, Year)	32. Regis of s Signa	10 N. Greens	Street	Baltimore AD allel
	Sta Regist		APR 2	2 7 2005 A	H houth		

202			For State Registrar	State of Mary		artment of He rtificate of D		lental Hy	giene Reg. No.	005	14289
			Decedent's Name (First, Middle, La	st)				2. Date of De	ath	V	3. Time of Death
	Physicia /Medic		George	Ne1son	1			April	22 <b>,</b> 2	005 <sup>Year</sup>	7:50 P M
	Examin		4a. Facility Name (If not institution, given 1010 St. Paul Str			4b. City, Town, or Lo Baltimor			4c. C	ounty of Death	1
	F				yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Bir	th	9. Birth	place (State or Foreign
Н	Funeral Director				80 Yrs.	Months Days	Hours Min.	May 9,	1924	In	linois
•	and w	}	Usuel Residence of Decedent  10a. State 10b. County	10	c. City, Town or Lo	cation					10d. Inside City Limits
	Maryla f sho	ō	Mary1and			more City					1 XYes 2 □ No
	r 28a	Funeral Directo	10e. Street and Number		· ·	10f. Zip Code			10g. Citize	n of Whal Cou	untry?
	th wit	alD	1010 St. Paul St	reet Apt	<b>4</b> H	21202			Unit	ed Stat	ces
	items items	nuel	11. Marital Status	12. Was Decedent Eve Armed Forces?	r in U.S. 13.	Was Decedent of Hisp If Yes, specify Cuban,	panic Origin? (Spe Mexican, Puerto	ecify Yes or No Rican, etc.)	D- 14	. Race - Amer Black, White	
36	be filed within 72 hours after death with the Maryland ital Hygiene. So other than "natural; or Itams 23e or 28e-f show so other than "natural; or Itams 29e or 28e-f show event, the Medical Examinating instituted at	by F	1 Never Married 2 Married 3 Widowed 4 Divorced	1 TYes 2 No If Yes, Give Year or Dates:	WWII	1 □ Yes 2 1 X No	Specify:		S	pecify: W	nite
21215-0036	72 hou	Completed by	15. Decedent's E (Specify only highest gr		16a. Dece	dent's Usual Occupation	on ring most of worki	ina		of Business/I	
21	c . 3	mple	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retired) ability Ad		9		al Secu nistrat	•
d 21	Hygiel Hygiel Ather ti	e Co	17. Father's Name (First, Middle, Last	)	D13		8. Mother's Name	(First, Middle			
Maryland	2 should be filed withir and Mental Hygiene. Is marked other than aumatic event, the Mental aumatic event, the Mental aumatic event, the Mental aumatic event.	To Be	Barnhard Philli				He1en		_	hnson	
ary	should and Men s marke rumatic	_	19a. Informant's Name/Relationship		19b. Mailii	ng Address (Street an		il Route Numb			ip Code)
	5 5 £ 5		Mary Lou Kitchne			llis Drive	-				
Baltimore,	0 0		20a. Method of Disposition  1  Burial 2  Cremation 3 ( 4  Donation 5  Other (Speci	Removal from State	20b. Place of Dispo cemetery, cres <b>tiverdale</b> P	nsition (Name of matory or other place) ark Crematory		Date 05		ation - City or 1 lale, Mar	
Balt	permit. Pag Department Importent: i any injury o		21. Signature of Entry Oservice Lice	MOI		2. Name and Address 221 Grayburn				nie, MD	21061
			23a. Part1. Enter the disease, or con shock, or heart failure. List only	plications that caused the	death. Do not en	er the mode of dying,	such as cardiac o	or respiratory a	ırrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Arterioscl	erotic Ca	ardiovascu	lar Dise	ase			Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a co							
		ler	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. — Due to (or as a co	onsequence of):						
B	cuted nd ransit	Examiner	that initiated events	c							
68760,	icate be executed physician and s the burial-transit	I Ex	resulting in death) Last	Due to (or as a co	onsequence of):						
387	physic physic the t	edical	•	d							
Box (	eath certific attending p		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of p		Ectopic pregnancy			23	d. Date of deli-	,
.O. B	The law requires that the death certif ste has been signed by the attending page 2 should be detached for use a	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐ Pregnant at tim 9☐ Unknown		Other (specify)				Month	Day Year
Δ.	res that the de signed by the a be detached t	by Ph	Part II. Other significent conditions	contributing to death but n	ot resulting in the u	nderlying cause given	in Part I.	23e. Did	tobacco use	contribute to	the cause of death?
Records,	w requires been sign	ed b						1 🗆	Yes 2□	No 3 ☐ Pro	obably 4 DUnknown
eco	e iaw requ has been je 2 shoul	Completed						24a. Was		24b. Were aut	topsy findings available completion of cause of
_	The cete h	Соп						1 Tes	ormed? 2 No	death?	2 No
Vital	ician: Th certificete rector, pag	Be	25. Was case referred to medical examiner?	Hospital:		Other	26. Place of Death				
of	Attending Physician: The ir death. c death. ector: After this certificete his by the funeral director, page	To To	1X Yes 2 No 27. Manner of Death	28a. Date of Injury (Month, Day Ye	2 ER/Outpatie	II 3 DOA	4   Nursing Ho	me 5 ☐ Res 28d. Describe			my) at scene
ion	ttending death. ctor: Afte y the fun	atlo	XXNatural 5 ☐ Pending 2 ☐ Accident investigate		ear) Injury		s 2 No				
Division	r Atte ter de irecto	Certification;	3 Suicide 6 Could not determined	28e. Place of Injury building, etc. (	- At home, farm, st Specify)	reet, factory, office			(Street and wn, State)	Number or Ru	ral Route Number,
	pital c		20s Cartifica III Cartifying B	hydriana. To the heat of a	ben ad da.a da.a.	h	data and class				
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical		hysician: To the best of n miner: On the basis of ex and manner stated	amination and/or in						
	To the To the comp	Me	29b. Signature and title of certifier			29c. License r	number			signed (Month	
•	1,			mis		OCME			aprı1	24, 20	
	1		30. Name and address of person who	completed cause of deat	h (Item 23a) (Type,		Onn Ctar	ot Pa	1+4	wa Ma-	mrland 01001
	∝ Sta	ite	31. Date filed (Month, Day, Year)	32. Registrar's			Penn Stre	et ba	тетіію.	re, mar	yland 21201
F	Regist		APR 2 7 200	5 Maria	It for	W.					

amend item#9,10f,112,16a-b,17,18,19a-b,20a-c,22, perfit, 345,7,27/05. TT

State of Maryland / Department of Health and Mental Hygiene, 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death ROBERT Month **Physician** OWEN 8:50 PM 05 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** KENSINGTON NURSING HOME KENSINGTON MONTGOMERY If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Y Jan 1, 1 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreig **Funeral** Days 1938 Hours 1 X M 2 □ F Washington Unit 577-52-6211 67 Director Usual Residence of Decedent Show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Items 23a or 28a-f show the Medical Evaluat must be notified at Director 1 ☐ Yes 2 ☑ No MD Montgomery Kensington death with the 10e. Street and Number 10f. Zip Code 20895 10g. Citizen of What Country? 3000 McComas Avenue 20910 USA unk 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. within 72 hours after 1 Yes 2 No tf Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 Yes 21 No Specify: Specify: white ð 3 ☐ Widowed 4 X Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Mechanic unk unk Automotive other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) unk h and Mental I unk Charles A. Owen, Sr. Eleanor Ruth Seaton 19 Informant Name (Belationship (Type, Print) 4011 Novar Drive, Chantilly, VA 20151 State, Zip Code) If item 27 I Kensington Nursing Home 3000 McComas Avenue Kesington, MO other t Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Pages ' 1 Burial 2 \*\*Cremation 3 Removal from State permit. Page Department of Important: If any injury or once. injury or National Crematory 4 □ Donation 5 Nomer (Specify) in state 7/23/05 Falls Church, VA 22 Name and Address of Facility Denaine Hineral Hone 520 S. Washington State Anatomy Board by Wilson Ballimore Street Ballimore, 115 21201 St. Alexandria, VA 22314 21. Signature of Funeral Sirvice Licensee Ronald S. W. 23a. Pant 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each time. Approximate Interval Between Onset and Death Immediat ause (Final disease or condition resulting in death) Pneumonia Physician unknown /Medical Due to (or as a consequence of): Congestive Heart failure Examiner Linkswown Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner certificate be executed burial-transit postate ancer unknown Due to (or as a consequence of) Box 68760. physicien Physiclan/Medical the ettending IF FEMALE use a 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetat death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy or in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4 Pregnant at time of death 5 Other (specify) Ö the detached 9 Unknown 9 🗆 Unknown à ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 Yes 2 No 3 Probably 4 Onknown Completed failure 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 certificate has Vital 1 Yes 2 No funeral director. Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner Other: 4 Downsing Home 5 Residence 6 Other (Specify) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA 1 🗌 Yes 2 No P o this 27. Manne of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 28d. Describe how injury occurred After Division or Attending 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident the Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide after within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 04/19/05 Chowdby, mo 043/21 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CHOWDHURY, MD; 5141 KING CHARLES WAY; BETHESDA, MD 20814

Registrar

State

31. Date filed (Month, Day, Year)

APR 2 7 2005

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** WENS VIA /Medical 4c. County of Death Facility Name (If not institution, give street and number) City, Town, or Location of Death **Examiner** Date of Birth (Month, Day, 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Days Hours Min -76-914 1**X**M 2□ F Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State Item 27 is marked other than "natural", or Itema 23a or 28a-f show other traumatic event, the Medical Erania and must be notified at 1 XYes 2 □ No Directo MARYLAND 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? MONROE Completed by Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 2 should be filed within 72 hours after and Mental Hygiene. 1 Never Married 2 Married 1 ☐ Yes 2 💆 No Specify: Specify: BLACK 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry(ロルズルロルン) College (1-4or 5+) Elementary/Secondary (0-12) Hygiene. 9 THGRADE TANDY MAN 18. Mother's Name (First, Middle, Maiden Sumame) (MN – นก หมอนค) 17. Father's Name (First, Middle, Last) OWENS JAMIE LVIN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 Department of Health Important: If Item 27 10 N. MONROE ST. BALTO, MD. 21211 BELINDAJOHNSO 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1XBurial 2 Cremation 3 Removal from State MEMORIAL PARKO4-28-05 WOODLAWN, MARYLAND any injury once. KING \* 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility BROWN JR. FUNERAL HOME 2190 N. FULTON AVE. BALTO, MD 21217 21. Signature of Funeral Service Licensee Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to fur as a consequence of it. Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Year Day 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ page 2 should be 1 ☐ Yes 2 1 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 2 No 1 ☐ Yes fo the Hospital or Attending Physician: 25. Was case referred to medical examiner? director. Be 26. Place of Death (Check only one) Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 3□ DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification; 1 Natural 5 Pending investigation after death. М 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 🗀 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined filled in by 4 Thomicide within 24 hours a

To the Funeral C

completely filled i 1 Decrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 97/45 (Type, Print) 30. Name and address of person who completed cause of death (Item 23a)

DHMH 17 Rev 1/2001

State Registrar Baltimore, Maryland 21215-0036

1. Deceden	Unpend I						inouto c	, Dout		2. Date of		NO.		3. Time	of Death
			01iv							April	17,	<sup>Day</sup> 200	5 Year	0055	Α
Clare	Name (If not ins	titution, aive					4b. City, Tow	n, or Locatio	n of Death	T.	Ť		nty of Deat		
	Fenwick			•			Silver	Sprin	ıg			Mont	gomer	<b>T</b> V	
	ecurity Number	6. Se		7. Age (In	yrs. last	t birthday)	If Under 1 Ye	ar If Und	er 24 Hrs.	8. Date of (Month,	Birth		<u> </u>	hplace (State untry)	or Fore
064-3	32-0619	1 2	M 2□F	65	5	Yrs.	Months Da	ys Hours	Min.	Feb.			Mary		
	dence of Decede														
10a. State	10b. C	ounty		100	c. City, T	Town or Lo	cation							10d. Inside	-
Mary1	and Mon	tgomen	ry	Si	ilve:	r Spr	ing							1 [_] Ye	s 2 🛣
	and Number						10f. Zip Cod	le			10g.	Citizen o	f What Co	untry?	
1400	Fenwick	Lane	#710				2091	.0			Un	ited	Stat	es	
11. Marital			12. Was Dece Armed Fo	edent Ever	in U.S.	13.	Was Decedent	of Hispanic (	Origin? (Sp	ecify Yes or	No-			rican Indian,	
1∭ Nev	ver Married 2	Married	1 Tyes	2 🔀 No			1 □ Yes 2X			rican, etc.			lack, White	e, etc.	
3 🗆 <b>W</b> id	dowed 4 □ Div	rorced	If Yes, Giv Year or D				TES ZA	No <i>Speci</i> i	y.			Spec		lack	
		cedent's Edi	ucation de completed)		1	16a. Dece	dent's Usual Oc kind of work do	cupation	ast of work	rina	161	o. Kind of	Business/	Industry	
Elementa	ary/Secondary (0		College (1	1-4or 5+)	-	life.	DO NOT use re	tired)	oot or work	9					
	1				(	Owner	-Operat	or			N	ight	club		
17. Father's	s Name (First, M	liddle, Last)						18. Mo	ther's Nam	e (First, Mid	dle, Mai	den Sum	ame)		
Colie	0liver							Hat	tie W	ilson					
	nant's Name/Rel	ationship (T	ype, Print)		-	19b. Maili	ng Address (Str	eet and Num	ber or Rur	al Route Nu	nber, C	ity or Tow	m, State, Z	Cip Code)	010
Yvonn	ne G. Ne	smith			8	8320	Colesvi	11e R	d. #1	03. BI	do	3 - S-	ilver	Sprin	910
	d of Disposition	<u> </u>		2	Ob. Plac	e of Dispo	sition (Name o	f		Date				Town, State	
	urial 2 Crem						natory or other		4-23	3-05	М-,		111.	0.0	
	onation 5 ☐ Ot ure of Funeral Se				1ayes		e Cemet	-			ma	yesv.	ille,	SC	
21. Signati		TO CONTRACTOR OF THE PARTY OF T	I)	#60	1034.				1 - 17731	0 0 1			- 22	V 12	
1	lancy	5%.	Nes	sec	e	لاسلسم	ob's Mc	Ituar	y, JI	Z 5. F.	laIII	St.	, Sum	ter, S	C Z
23a. Part1	. Enter the pisea	e r comp	lications that c											A	-4-
shock	k, or he ift ailur	e. List Offing C	one cause on e	each line.	death.	Do not en	er the mode of				y arrest			Approxim Interval B	etween
Immediate disease or	k, or he ift ailur. Cause Final condition	e. List offiny o	ne cause on e	each line.							y arrest			Approxim Interval B Onset and	etween
Immediate	k, or he ift ailur. Cause Final condition	s. Jeist Offiy C	a. Cocai	each line.	ntox	cicat					y arrest			Interval B	etween
Immediate disease or resulting in	k, or he it allur e Cause Final r condition n death)	ſ	a. Cocai	each line. ine I	ntox	cicat					y arrest,			Interval B	etween
Immediate disease or resulting in	k, or he in allur, a Cause Final r condition n death)	ſ	a. Cocat  Due to	each line. ine I	ntox	cicat nce of):					y arrest			Interval B	etween
Immediate disease or resulting in Sequential if any, lead cause. En Cause (Lie	k, or he if allur cause Final condition death) lly list conditions ding to immediate ther Underlying	ſ	a. Cocat  Due to	each line.  ine I  (or as a co	ntox	cicat nce of):					y arrest			Interval B	etween
Immediate disease or resulting in Sequential if any, lead cause. En Cause Unit that initiate	k, or he if allur cause Final condition death) lly list conditions ding to immediate ther Underlying	ſ	a. Cocad  Due to  Due to	each line.  ine I  (or as a co	ntox onsequer	ricat nce of):					y arrest,			Interval B	etween
Immediate disease or resulting in Sequential if any, lead cause. En Cause Uksthat initiate	k, or he if allur, a Cause (Final r condition n death)  Illy list conditions ding to immediate ter Underlying bedeut or if july and events	<b>\{</b>	a. Cocai  Due to  Due to	each line.  ine I  (or as a co	ntox onsequer	ricat nce of):					y arrest			Interval B	etween
Immediate disease or resulting in Sequential if any, lead cause. En Cause Cult that initiate	k, or he if allur, a Cause (Final r condition n death)  Illy list conditions ding to immediate ter Underlying bedeut or if july and events	<b>\{</b>	a. Cocad  Due to  Due to	each line.  ine I  (or as a co	ntox onsequer	ricat nce of):					y arrest,			Interval B	etween
Immediate disease or resulting in Sequential if any, lead cause. En Cause (Like that initial resulting in IF FEMALE	k, or he ft allur, o Cause Final condition heath)  Ily list conditions ding to immediate the Underlying because of the list of the conditions of the list of the l	{	a. Cocai  Due to  Due to  Due to  Due to	ine I (or as a co (or as a co (or as a co	ntox onsequer onsequer	nce of):					y arrest,		Data of dal	Interval B Onset and	etween
Immediate disease or resulting in Sequential if any, lead cause. En Cause Det that initiate resulting in IF FEMALE 23b. Was a in the	k, or he ft allur, o Cause Final r condition in death)  Illy list conditions ding to immediate the Underlying second of the conditions in death) Last  E: decedent pregna past 12 months	e {	a. Cocat  Due to  Due to  Due to  C. Due to  23c. If yes, out	ine I (or as a co (or as a co (or as a co	ntox onsequer onsequer onsequer regnance	ricat.  nce of):  nce of):  nce of):	<b>ion</b>	dying, such			y arrest,	23d. [	Date of deli	Interval B Onset and	etween
Immediate disease or resulting in Sequential if any, lead gause. En that initiate resulting in IF FEMALE 23b. Was in the 1 17 the control of	k, or he ft alluri o Cause Final condition n death)  Illy list conditions ding to immediate the Underlying sode of many ad events n death) Last	e {	a. Cocat  Due to  Due to  Due to  C. Due to  23c. If yes, out	each line.  ine I  (or as a co  (or as a co  (or as a co  tcome of pi	ntox onsequer onsequer onsequer regnance	ricat.  nce of):  nce of):  nce of):	ion	dying, such			y arrest,	23d. [		Interval B Onset and	etween d Death
Immediate disease or resulting in Sequential if any, lead gause. En Cause Die that initiate resulting in IF FEMALS 23b. Was 6 in the 1 Y 9 U C	k, or he ft alluri o Cause Final r condition death)  Illy list conditions ding to immediate ter Underlying bode or in let death) Last  E: decedent pregna past 12 months (es. 2 □ No Jnknown	int?	b. Due to  Due to  Due to  Due to  Due to  Due to  Due to  Due to  Due to  Due to	each line.  ine I  (or as a co  (or as a co  (or as a co  tcome of p)  orth 2   nant at time own	ntox onsequer onsequer onsequer regnanc; Fetal de	ricat.  nce of):  nce of):  y  aath 3[  th 5[	ion	ancy	as cardiac	or respirator	_	23d. [	Month	Interval B Onset and Onset and Onset and Onset and Onset and Onset and	etween d Death
Immediate disease or resulting in Sequential if any, lead gause. En Cause Die that initiate resulting in IF FEMALS 23b. Was 6 in the 1 Y 9 U C	k, or he ft allur p Cause Final condition n death)  Illy list conditions ding to immediate the Underlying bedder in july a death) Last  E: decedent pregna p past 12 months fes 2   No	int?	b. Due to  Due to  Due to  Due to  Due to  Due to  Due to  Due to  Due to  Due to	each line.  ine I  (or as a co  (or as a co  (or as a co  tcome of p)  orth 2   nant at time own	ntox onsequer onsequer onsequer regnanc; Fetal de	ricat.  nce of):  nce of):  y  aath 3[  th 5[	ion	ancy	as cardiac	or respirator	id tobac	23d. [	Month ontribute to	Interval B Onset and	Year death?
Immediate disease or resulting in Sequential if any, lead august. En Cause District that initiate resulting in IF FEMALS 23b. Was a in the 1 Y 9 U to	k, or he ft alluri o Cause Final r condition death)  Illy list conditions ding to immediate ter Underlying bode or in let death) Last  E: decedent pregna past 12 months (es. 2 □ No Jnknown	int?	b. Due to  Due to  Due to  Due to  Due to  Due to  Due to  Due to  Due to  Due to	each line.  ine I  (or as a co  (or as a co  (or as a co  tcome of p)  orth 2   nant at time own	ntox onsequer onsequer onsequer regnanc; Fetal de	ricat.  nce of):  nce of):  y  aath 3[  th 5[	ion	ancy	as cardiac	or respirator	_	23d. [	Month ontribute to	Interval B Onset and Onset and Onset and Onset and Onset and Onset and	Year death?
Immediate disease or resulting in resulting in Sequential if any, lead cause. En Cause Cutton	k, or he ft alluri o Cause Final r condition death)  Illy list conditions ding to immediate ter Underlying bode or in let death) Last  E: decedent pregna past 12 months (es. 2 □ No Jnknown	int?	b. Due to  Due to  Due to  Due to  Due to  Due to  Due to  Due to  Due to  Due to	each line.  ine I  (or as a co  (or as a co  (or as a co  tcome of p)  orth 2   nant at time own	ntox onsequer onsequer onsequer regnanc; Fetal de	ricat.  nce of):  nce of):  y  aath 3[  th 5[	ion	ancy	as cardiac	23e. D	id tobac □ Yes *asan	23d. [ co use cc 2 [ 40	ontribute to	ivery Day  the cause of obably 4 [	Year  death?
Immediate disease or resulting in Sequential if any, lead august. En Cause District that initiate resulting in IF FEMALS 23b. Was a in the 1 Y 9 U to	k, or he ft alluri o Cause Final r condition death)  Illy list conditions ding to immediate ter Underlying bode or in let death) Last  E: decedent pregna past 12 months (es. 2 □ No Jnknown	int?	b. Due to  Due to  Due to  Due to  Due to  Due to  Due to  Due to  Due to  Due to	each line.  ine I  (or as a co  (or as a co  (or as a co  tcome of p)  orth 2   nant at time own	ntox onsequer onsequer onsequer regnanc; Fetal de	ricat.  nce of):  nce of):  y  aath 3[  th 5[	ion	ancy	as cardiac	23e. D	☐ Yes ☐ Yes ☐ tobacc	23d. [	ontribute to	ivery Day  the cause of obably 4 [ ttopsy finding completion of	Year  death?
Immediate disease or resulting in resulting in any lead cause. En Cause En Cause in that initiate resulting in the 1 Y 9 U to Part II. Oth	k, or he ft allure of Cause Final r condition of death)  Illy list conditions ding to immediate ther Underlying bace of milery devents of death) Last  E. decedent pregna past 12 months fes 2 \sum No Jnknown her significant co	ant ?	b. Due to  Due to  Due to  Due to  Due to  Due to  Due to  Due to  Due to  Due to	each line.  ine I  (or as a co  (or as a co  (or as a co  tcome of p)  orth 2   nant at time own	ntox onsequer onsequer onsequer regnanc; Fetal de	ricat.  nce of):  nce of):  y  aath 3[  th 5[	ion	ancy	as cardiac	23e. D	id tobac □ Yes fas an utopsy erformed s 2 □	23d. [	ontribute to	ivery Day  the cause of obably 4 [ ttopsy finding completion of	Year  death?
Immediate disease or resulting in Sequential if any, lead gause. En Cause Die that initiate resulting in the 1 Year 11	k, or he ft allur of Cause Final condition of death)  Illy list conditions ding to immediate the Underlying because it is in t	ant?	Due to Du	each line.  ine I  (or as a co  (or as a co  (or as a co  tcome of piointh 2   ant at time own	ntox onsequer onsequer onsequer oregnance Fetal de e of deat	nce of):  y and a set of the set	Ectopic pregna Other (specify	ancy given in Pa	rt I.	23e. D 1 24a. W at	id tobace  Yes fas an utopsy erformes  2 [ fv one)	23d. [	ontribute to  3   Property of the prior to code ath?  1   Yes	ivery Day  the cause of obably 4 [ topsy finding completion of 2 [] No	Year  death?  Unknow  s availal  cause 6
Immediate disease or resulting in Sequential if any, lead gause. En Cause Litt that initiate resulting in the 1 Year 11. Oth	k, or he ft allure of Cause Final condition of death)  Illy list conditions ding to immediate ther Underlying because it is in the condition of death)  E: decedent pregna of past 12 months fes 2 \sum No Jnknown  ter significant con asse referred to meer?  ss 2 \sum No	ant?	Due to Du	each line.  ine I  (or as a co  (or as a co  (or as a co  tcome of pi  pinth 2   annt at time  own  leath but no	ntox onsequer onseque	ricat.  nce of):  nce of):  y aath 3[ th 5[  ng in the u  N/Outpaties  Bb. Time o	Ectopic pregni	ancy  given in Pa	rt I.	23e. D 1 24a. W	id tobace  Yes  Res an  utopsy enformees  2 [ // one)	23d. [ co use cc 2 [ ] 70 24t 17 No	ontribute to  3 Pro  D. Were au prior to c death?  1 (Spec	ivery Day the cause of obably 4 [ topsy finding completion of 2   No	Year  death?  Unknow  s availal  cause 6
Immediate disease or resulting in Sequential if any lead cause. En Cause En	k, or he ft allure of Cause Final condition of death)  Illy list conditions ding to immediate ter Underlying seator in july devents of death) Last  E. decedent pregna past 12 months (es 2 □ No Jnknown  ter significant co	ant?	Due to Du	ine I (or as a co (or as a co (or as a co tcome of p) birth 2  binant at time own leath but no	ntox onsequer onseque	ricat.  nce of):  nce of):  y aath 3[ th 5[  ng in the u  N/Outpaties  Bb. Time o	Ectopic pregnal Other (specify nderlying cause At 28c.	ancy 26. Pla Other: 4 niury at Work?	as cardiac  It I.	23e. D 1 24a. W at pe	id tobace  Yes  Res an  utopsy enformees  2 [ // one)	23d. [ co use cc 2 [ ] 70 24t 17 No	ontribute to  3 Pro  D. Were au prior to c death?  1 (Spec	ivery Day  the cause of obably 4 [ topsy finding completion of 2 [] No	Year  death?  Unknow s availat cause c
Immediate disease or resulting in Sequential if any, lead cause. En Cause Cutte that initiate resulting in IF FEMALE 23b. Was to in the 1 Ye 9 U C	k, or he ff allure of Cause Final r condition in death)  Illy list conditions ding to immediate ther Underlying because it is a light of the condition and a light of the conditions in death) Last  E: decedent pregna go past 12 months fes 2 \( \) No Juknown  Interest in death  In	ant?	Due to Du	ine I (or as a co (or as a co (or as a co (or as a co tcome of p) birth 2  anat at time own leath but no	ntox onsequer onseque	ricat.  nce of):  nce of):  nce of):  nce of):  y aath 3[ th 5[  ng in the u  NOutpaties Bb. Time of Injury.  Tournd	Ectopic pregnal Other (specify) Inderlying cause  at 3 DOA f 28c.	ancy  given in Pal  26. Pla  Other: 4  njury at Work? 1   Yes 2	rt I.	23e. D  24a. W  au  Check on  me 5 R  28d. Descrit	id tobace Yes Yes As an stopsy reformes S 2 (v one) esidence se how	23d. [ ] co use cc 2 1 10 24t d? No e 6 🔊 Co	ontribute to  3 Pro  Were au prior to dealt? 1 Pro  ther (Spec	ivery Day  the cause of obably 4 [  ttopsy finding completion of 2   No  city) At  unk	Year  death?  Unknow s availat cause of
Immediate disease or resulting in resulting in Sequential if any, lead gause. En Cates Little that initiate resulting in the 1 Year II. Oth	k, or he ff allure of Cause Final r condition in death)  Illy list conditions ding to immediate ther Underlying because it is a light of the condition and a light of the conditions in death) Last  E: decedent pregna go past 12 months fes 2 \( \) No Juknown  Interest in death  In	ant?	Due to Du	ine I (or as a co (or as a co (or as a co tcome of pi pinth 2  nant at time own leath but no leath but no linpatient of Injury Day Ye O o o o o o o o o o o o o o o o o o o	onsequer ons	ricat nce of): nce of): nce of): y aaath 3[ th 5[ w Outpaties b. Time of injury ound 12:55 e, farm, st	Ectopic pregnal Other (specify nderlying cause At 28c.	ancy  given in Pal  26. Pla  Other: 4  njury at Work? 1   Yes 2	as cardiac  It I.  It I.  It I Deat	23e. D  24a. W  apple  th (Check on ome 5   28f. Locatio  City or	id tobace  Yes fas an stopsy erformes s 2 [ fv one) esidence be how  n (Stree	23d. [ ] 23d. [ ] 23d. [ ] 23d. [ ] 23d. [ ] 24d.  ontribute to  3 □ Pro  Were au prior to c death? 100 Ves  Other (Specurred	ivery Day the cause of obably 4 [ topsy finding completion of 2   No	Year  death?  Junkno s availates cause	
Immediate disease or resulting in resulting in any, lead cause. Encause. En	k, or he ft allure o Cause Final r condition It is condition I	ant?  pending nyestigation Could not be determined	Due to Du	ine I (or as a co (or as a co (or as a co tcome of piointh 2 and at time nown leath but no leath but no linpatient of Injury (i) Day Ye     of Injury ing, etc. (S  at r	onsequer onsequer onsequer onsequer onsequer onsequer oregnance Fetal de e of deat ot resultin	y sath 3 [  The of):  YOutpaties  Noutpaties  Noutpati	Ectopic pregnar Other (specify nderlying cause At At Meet, factory, off	ancy  given in Par  26. Pla  Other: 4  Injury at work?  1 Yes 3	nt I.	23e. D 1 24a. W au Pe th (Check on ome 5 R 28d. Descrit City or Silver	id tobace  Yes  Fas an utopsy erformes s 2 // // one) esidenc pe how  (Stree Town, S	23d. [2] co use cc 2 [3] 24t d? No e 6 SC injury occ it and Numitate) 14 ing,	ontribute to  3 □ Pro  D. Were au prior to o death? 1 □ D. Wes  Other (Spec	ivery Day  the cause of obably 4 [ topsy finding completion of 2 No  unk  unk  enwick	Year  death  Unknown  s availate  cause
Immediate disease or resulting in resulting in any lead cause. En Cause in that initiate resulting in the 1 Ye 1 Ye 25. Was consumed in the examination of the examin	k, or he ft allure of Cause Final r condition of death)  Illy list conditions ding to immediate ter Underlying state or high death) Last  E.  decedent pregna past 12 months res 2 No Jnknown er significant co ase referred to mer? ase 2 No or of Death tural 5 1 coident uicide 6 7 comicide  Tier 1 Ce ek only 2 Mer	ant?  pending nedical  Pending Could not be determined	Due to Du	ine I (or as a co (or as a co (or as a co (or as a co (or as a co (or as a co  tcome of p pinth 2  nant at time own  linpatient of Injury Day Ye 05 e of Injury - ing, etc. (S at r abesis of exacts	onsequer ons	ricat nce of): nce of): nce of): y aaath 3[ th 5[ w) Outpaties Bb. Time of Injury Tound 12:55 e, farm, st lence edge, deat	Ectopic pregnal Other (specify) Inderlying cause  at 3 DOA f 28c.	ancy  given in Pa  26. Pla  Other: 4  nury at Work? 1 Yes 3	nt I.	23e. D  24a. W  and  28d. Descrit  28f. Locatio  City or  and due to t	id tobace  Yes  fas an  stopsy erformed s 2 [ fv one) esidence be how  n (Stree Town, S Spi he caus	23d. [2] co use cc 2 No 24t 27 No e 6 800 injury occ strand Num itate) 14 ring, se(s) and i	ontribute to  3 □ Pro  Description to a death? 10 Description of Runner or Runner as	ivery Day  the cause of obably 4 topsy finding completion of 2 No  unk  iral Route Nue iral Rout	Year  death?  Year  death?  Scer
Immediate disease or resulting in resulting if any lead cause. En Cause that initiate resulting in the 1 23b. Was on the 1 2 3b. Was on the 1 3b. Was o	k, or he ft allure of Cause Final r condition of death)  Illy list conditions ding to immediate ter Underlying state or high death) Last  E.  decedent pregna past 12 months res 2 No Jnknown er significant co ase referred to mer? ase 2 No or of Death tural 5 1 coident uicide 6 7 comicide  Tier 1 Ce ek only 2 Mer	ant?  anditions conditions condit	Due to Du	ine I (or as a co (or as a co (or as a co (or as a co tcome of pi pinth 2  nant at time own leath but no leath but no leath but no leath but no leath but no leath color injury of no fi ping, etc. (S  at r  e best of m	onsequer ons	ricat nce of): nce of): nce of): y aaath 3[ th 5[ w) Outpaties Bb. Time of Injury Tound 12:55 e, farm, st lence edge, deat	Ectopic pregnal Other (specify) Int 3 DOA f 28c. At The real, factory, off	ancy  given in Pa  26. Pla  Other: 4  nury at Work? 1 Yes 3	as cardiac  It I.  It Ce of Deat  Nursing Ho  I No  and place, eath occur	23e. D  24a. W  and  28d. Descrit  28f. Locatio  City or  and due to t	id tobace  Yes  Yes  Yes  Yes  Yes  Yes  Yes  Y	23d. [2] co use cc 2 [3] line 17 line e 6 20 cinjury occ tand Num citate) 14 cing, ee(s) and n and place	ontribute to  3  Pro  Were au prior to c dealt?  1  Ves  Other (Spec urred	ivery Day  the cause of obably 4 topsy finding completion of 2 No  unk  iral Route Nue iral Rout	Year  death?  Year  death?  Lar

ed by the attending physician and detached for use as the burial-transit naral Diractor: After this certificate has been signed by I filled in by the funeral director, page 2 should be detact s after death.

Hospital or Attanding Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

**Physician** /Medical Examiner

57

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of

29c. License number **OCME** 

29d. Date signed (Month, Day, Year) April 17, 2005

ause of death (Item 23a) (Type, Print) 30. Name and address of

4-

111 Penn Street Baltimore, Maryland 21201

State Registrar

MLS 12 31. Date filed (Month, Day, Year) 32. Registres Signature 2005

within 24 hours a To the Funeral E

		For State Registrar	State of Maryla	nd / Depa		lealth and M	Mental Hy		005	14293
Physic		Decedent's Name (First, Middle, L.      Wrffe	Plack				2. Date of De Month April	ath Dey 22 20	Yeer 105	3. Time of Death 6:35 P M
/Med Exam Funera	iner		Sex 7. Age (In yrs	s. last birthday)	4b. City, Town, of Baltimor	e County  If Under 24 Hrs. Hours   Min.		4c. C	ounty of Deeth	plece (State or Foreign
Directo		215         16         2208           Usual Residence of Decedent           10a. State         10b. County	1□ M 2 X F 9/4	Yrs. City, Town or Lo			June 3 1	910	Balt	imore City, M
th the Mary or 28a-1 sh	Oirector	Maryland Baltimor	e B	altimore	10f. Zip Code			10g. Citize	en of What Cou	1 ☐ Yes 2 ☐ No Intry?
Ind 21215-0036  be filed within 72 hours after death with the Maryland tial Hygiene.  Ind other than "natural", or Items 23s or 28s-f show event, the Medical Evarities matched in confined at	by Funeral Director	9101 Bowline Road  11. Marital Status  1 Never Married 2 Married	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give		21236 Was Decedent of If Yes, specify Cub 1 □ Yes 2 □ No	Hispanic Origin? (S an, Mexican, Puert Specity:	pecify Yes or No o Rican, etc.)		4. Race - Ameri Black, White,	, etc.
21215-0036 sol within 72 hours aff gilene. or than "natural", or i, the Mudical Exerci-	Completed b	3 Widowed 4 Divorced  15. Decedent's (Specify only highest g  Elementary/Secondary (0-12)	rade completed)  College (1-4or 5+)	(Give		during most of wor d)	king		d of Business/Ir	ite ndustry
be filed ttal Hygind of other	To Be Col	17. Father's Name (First, Middle, Las	<u>N</u> √A	Accour	nting Clerk	18. Mother's Nar Hattie Ni		Bendi , Meiden S		
0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		19a. Informant's Name/Relationship Linda Plack 20a. Method of Disposition		9101 I		and Number or Ru		nd 212		
timen rtant:		1 ⊠ Burial 2 ☐ Cremation 3  '4 ☐ Donation 5 ☐ Other (Special Service Lice)	ify) F	ork Unite	ed Meth. Ch 2. Name and Addre	. Cem. Apri		Fork	k, Marylan	nd
Physiciai /Medica Examine	n M	23a. Part 1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)	mplications that caused the de y one cause on each line.	Stage	_	Road Balti ng, such as cardia nentia	more, Mar or respiratory a	yland West, nd	21236	Approximate Interval Between Onset and Death
decuted and and	cal Examiner		b. Due to (or as a const							
Box 68 sath certifica attending ph for use as th	by Physician/Medic		23c. If yes, outcome of preg 1   Live birth 2   Fe 4   Pregnant at time of	etel death 3	□Ectopic pregnand □ Other (specify)	y		23	3d. Date of deliv	very Day Year
De ta de ta	ed by Ph	Part II. Other significant conditions	contributing to death but not r	esulting in the	underlying cause g	ven in Part I.		tobacco us Yes 2		the cause of death?
I Re( The lavate has	Completed						24a. Was auto perfe 1 Yes		prior to co death?	topsy findings available completion of cause of 2 No
of Vital F Physician: Th rthis certificate ral director, pag	To Be	25. Was case referred to medical examiner?  1 Yes 2 No	Hospital: 1 Inpatient 2	ER/Outpatie	ent 3 DOA	her: Uursing H	ath (Check only Iome 5 Res 28d. Describe	idence 6		ify)
fing Afte fune	Certification:	2   Accident   S   Pending   2   Accident   Investigat   3   Suicide   6   Could not   determine   determine   Could not   determine   determine   Could not   Cou	(Month, Day Yeer)	Injury thome, farm, s	M 1	ork? ]Yes 2∐No	28f. Location		l Number or Ru	ral Route Number,
Hospita 24 hours Funeral tely filled	edicai Cer	29a. Certifier 1 Certifying (Check only one)	Physician: To the best of my keminer: On the basis of examiner stated.							
To the within 2 To the comple	Mec	29b. Signature and title of certifier		^		se number	2	29d. Date	signed (Month	
\varphi		Jude Capatingo	o completed cause of death (I	FRAIN	KINNOOD	is Bull	rimare	, Ni	(d/	
Regi	State strar	א האולו או או	2005	nature	hart o			,		

ORIGINAL

DHMH 17 Rev 1/2001

			State of Maryland / Department of Health and Mental Hygiene  1- State Registrar  Certificate of Death  Reg. No. 2 0 1 5 1 2 0 1				
			Registrar  Certificate of Death  1. Decedent's Name (First, Middle, Last)  2. Date of Death  3. Time of Death  3. Time of Death				
		sician	Elizabeth Phillips April 21 2005 11:00am				
		edical miner	4a. Fecility Name (If not institution, give street and number)  4b. City, Town, or Location of Death  4c. County of Death				
			Harford Memorial Hospital Havre de Grace Harford				
	Fune Direc		5. Social Security Number  6. Sex 1 M 2X F  7. Age (In yrs. last birthdey) 1 M Nonths 1				
		loi	Usual Residence of Decedent				
	rylan		10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1X Yes 2 □ No.				
	Ba-f	Director	MD Harford Havre de Grace				
	death with the Maryland ma 23a or 28a-f show	Dir.	10e. Street and Number 10f. Zip Code 10g. Citizen of Whal Country?  107 South Stokes Street 21078 USA				
	leath na 23	Funeral	11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-				
	15-0036 72 hours after death with the Marylar ratural; or itema 23s or 28s-f show	Fur	Armed Forces?  1 Never Married 2 Married 2 Married 1 Yes, specify Cuban, Mexican, Puerto Rican, etc.)  8 lack, White, etc.  1 Yes, 2 No  1 Yes, Give				
	DO3	d by	3 X Widowed 4 □ Divorced Year or Dates: White				
	15-0	Completed	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  16b. Kind of Business/Industry				
	212 within	dwo	Elementary/Secondary (0-12)  College (1-4or 5+)  2 years  Nursing Assistant  Nursing Home				
	e filec	Be C	17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Maiden Sumame)				
	Var Menta	10	Stewart Davis Trinie Vinson				
0	Maryland 21215-0036 at 2 should be filed within 72 hours alt th and Mental Hygiene. 77 is marked other than "natural", or		19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  132. S. Stalkon, St. Havkey, do. Crasco, MD, 21079				
	1 and 1 and 1 and 1 and 1 and 1		Judith L. Baldwin – Daughter 132 S. Stokes St., Havre de Grace, MD 21078  20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other place)  20c. Location · City or Town, State				
41	Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after dea Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or itema	5	1 X Burial 2 Cremation 3 Removal from State  4 Donation 5 Other (Specify)  Wesleyan Ch. Cem. 04/26/05  Aberdeen, MD				
0	mit Partim	ej ej	21. Signature of Funeral Service Licensee  22. Name and Address of Facility Mitchell-Smith Funeral Home, P.A.				
00 /	m &a E	8 8	123 S. Washington, Havre de Grace, MD 21078				
1			Approximate shock, or heart failure. List only one cause on each line.  Approximate Interval Between Onset and Death				
	Physic	_	Immediate Cause (Final disease or condition resulting in death)				
	/Medi Exami	_	Durity (or as a consequence of):  Seventially list conditions  Descriptions  Descriptions  Descriptions				
		e e	if any, leading to immediate Upue to (or as a consequence of):				
1	pd bd	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events  c. Drabetos				
35	60, 4 be executed ician and	Exe	resulting in death) Last  Due to (or as a consequence of):				
1/1	8760, acate be executed physician and	dicai	d. Kenal for curl				
#12		/Me	IF FEMALE: 23b Was decadent pregnant 23c. If yes, outcome of pregnancy 23d. Date of delivery				
1.	Box death cer	Physician/Me	in the past 12 months?    Uver birth   2   Fetal death   3   Ectopic pregnancy   Month   Day   Year   1   Ver   3   Month   Day   Year		o. o. o. o. o. o. o. o. o. o. o. o. o. o	hysi	9 Unknown
5	Records, P.O. Box 6 The law requires that the death certifi the has been signed by the attending	be de by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death?				
1	ord requir	should leted	1 Yes 2 No 3 Probably 4 Unknown				
Phillip	Vital Records, sician: The law requires t certificate has been signed	V Q	24a. Was an autopsy findings available autopsy performed? death?				
C		Com	1 Yes 2 No 1 Yes 2 No				
\	of Vita Physician: rthis certific	or Be	25. Was case referred to medical examiner?  1  Yes 2 No				
7	on of ling Phys	a   -	27. Manny'r of Death 28a. Date of Injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred				
et	Division or Attending after death. Director: Afte	led in by the tuneral Certification:	2 Accident investigation M 1 Yes 2 No				
B	Division of the nation of the deat deat Director:	n by the	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)				
	Division Hospital or Attending 14 hours after death. Funeral Director: After	S	29a. Certifier  1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				
	24 hc	pletely fill	(Check only one)  2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				
	Div To the Hospital or within 24 hours after To the Funeral Dire	compl	29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Dey, Year)				
		7	1 / Lu M.V. 12066 92405				
	1	U	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)				
	*	State	3. Date filed (Month, Day, Year)  32. Begistrar's Signature  32. Begistrar's Signature				
	Re	State gistrar	APR 2 7 2005 Beau & April 2				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician 1:45 PM APRIL 4a. Fecility Name (If not institution. 2005 /Medical give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner HEALTH CARS BALTIMORS AGNES SAIHT 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country)

Mary and 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 100M 2□F 220-14-757 Yrs. Director Usual Residence of Decedent 10a State 10d. Inside City Limits 10b. County 10c. City, Town or Location 27 is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Examinar must be notified at 1 ⊠Yes 2 No Director actimore d 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 3526 1216 hapel Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify. 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) To Be Williams dwards 19a. Informant's Name/Relationship (Type, Print) | Friend 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health of tem 27 i Baltimore, Md. 21216 VONDE 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Surial 2 ☐ Cremation 3 ☐ Removal from State 4-26-2005 Woodlawn • 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fundral Service Licent ZZZZW. NORTH AVE 22. Name and A dress of Facility any in LRUSS FUNERAL HOME B1770 MB217/6 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final HYPERCHRBIC/HYPOXIC RESPIRATORY FAI LURE **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner 2 DAKS EXACERBATION COPD Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 2 Fetal death 3 Ectopic pregnancy 4☐ Pregnant at time of death Month Day Year 5 Other (specify) P.0. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

METASTATIC PROSTATE CANCER 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by METASTATIC 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 performed? Yes 2 No 1 ☐ Yes 2 No director. 25. Was case referred to medical examiner? Medical Certification: To Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 1 ☐ Yes 2 No Other: 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) within 24 hours after death.

To the Funeral Director: After the completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 27 Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 80060105 APRIL 20, 2005 person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 1/2001

State

XARL QUIST
31. Date filed (Month, Day, Year)

U157

900

tHERSOM

32. Registrar's signature

CATOH AVENUE, BALTIMORE MU21229

			For State Registrar	State of M		artment of Health a rtificate of Death		giene () () 5	14296
	Dhuaisi		1. Decedent's Name (First, Middle,	Last)			2. Date of Dea	ath Day Year	3. Time of Death
	Physici /Medio		TROY PRIVETTE				APRIL 1		3:58p M
	Examir	ner	4a. Facility Name (If not institution,		)	4b. City, Town, or Location of	Death	4c. County of Dea	ath
			1935 CLIFTON 5. Social Security Number		ge (In yrs. last birthday	BALTIMORE  If Under 1 Year   If Under 2	4 Hrs. 8. Date of Birt	N/A	rthplace (State or Foreign
ŀ	Funeral Director		240-62-2447	1⊠M 2□F	63 Yrs.	Months Days Hours	Min. (Month, Da)	y, Year) C	TH CAROLINA
	P .		Usual Residence of Decedent				, 101	J41 MOR	
	anylar show	2	MD . 10b. County		10c. City, Town or L BALTIMO				10d, Inside City Limits 1 X Yes 2 ☐ No
	hours after death with the Maryland tural', or Itame 23a or 28e-f show all Examitrac Indel be matilied at	Director	10e. Street and Number		BALITMO	10f. Zip Code		10- Citi	-
	with Mark			A 7717				10g. Citizen of What C	ountry ?
	death me 23	Funeral	1935 CLIFTON	12. Was Decedent	Ever in U.S. 13.	21217 Was Decedent of Hispanic Origi If Yes, specify Cuban, Mexican,	in? (Specify Yes or No-	USA - 14. Race - Am	erican Indian,
9	or ita	Ē	1 Never Married 2 Marrie				Puerto Rican, etc.)		
5-0036	urai',	d by	3 ☐ Widowed 4 € Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 ☐ No Specify:		Specify: B	LACK
2	be filed within 72 hours after death with the Marylan lat lytgiene. Id other than "natural", or itame 23a or 28e-1 show event. It a Medical Examine must be rediffed at	Completed	15. Decedent' (Specify only highest	s Education : grade completed)	(Give	edent's Usual Occupation a kind of work done during most ( DO NOT use retired)	of working	16b. Kind of Business	s/industry
2	within 72 ene. than "na"	mb	Elementary/Secondary (0-12)	College (1-4or	5+)			TOIRIG HOR	VINA WAADIDI
2	Hygin other	Be Co	-11- 17. Father's Name (First, Middle, L		MA	INTENANCE 18. Mother	's Name (First, Middle,		KINS HOSPITAI
au	should be nd Mental marked o	To B	ED PRIVETTE			SANN	NIE HINTON		
Maryland	and and sem		19a. Informant's Name/Relationsh	ip (Type, Print)	19b. Mail	ing Address (Street and Number	or Rural Route Numbe	er, City or Town, State,	Zip Code)
			EVELYN BURREL	L(FRIEND)		OLD COURT RD.		, MARYLAND	21208
altimore,	Pages 1 a nent of Hea nnt: If item iry or othe		20a. Method of Disposition 1 □ Burial 2 □ Cremation	3 □Removal from State	20b. Place of Disp cemetery, cre	osition (Name of matory or other place)	Date	20c. Location - City of	Town, State
Ē	permit. Pages Depertment of i importent: If it, any injury or o		'4 □ Donation 25 ☑ Other (Sp	pecify)	METRO CR	EMATORY 4-	-28-2005	BALTIMORE,	MARYLAND
Ba	Seper Seper mpor mp in		21. Sign up and an eral Service L	Copsee JONATHA		8. Name and Address of Facility			
	10110		23a. Part1. Enver the disease, or o	complications that cause		1721-27 N. MONR			RYLAND 21217 Approximate
			shock of heart failure. List of	only one cause on each li	ine.				Interval Between
	Physician /Medical		disease or condition resulting in death)	a. Due to for as	ATheeosc a consequence of):	leeotic Card	10 Vascul	al Diseas	e years
	Examiner			Due to (or as	a consequence or):				0
		Je.	Sequentially list conditions, if any leading to immediate cause. Enter Underlying	b. Due to (or as	a consequence of:				
	cuted nd ransil	Examin	Cause (Disease or injury that initiated events	с.					
Ď,	be executed icien and burial-transit		resulting in death) Last	Due to (or as	a consequence of):				
8760	ate hys the	dlcal		d.					
× Q	the death certific y the attending p iched for use as		IF FEMALE:	23c. If yes, outcome	of pregnancy			224 244	
Rox	atten atten	Physiclan/M	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant a	2 Fetal death 3	□Ectopic pregnancy □ Other (specify)		23d. Date of de Month	Day Year
o.	the d y the	ysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown					
ري ت	The law requires that te has been signed b age 2 should be deta	by P	Part II, Other significant condition		_	anderlying cause given in Part I.	23e. Did to	bacco use contribute t	o the cause of death?
īd	w require been sig should b		Hyperca	Cemia			1 🗆 Y	′es 2 No 3 □ P	robably 4 DUnknown
ecords,	law requas been 2 shoul	ompleted	feostate	Carcinon	R		24a. Was a autop		utopsy findings available completion of cause of
r		Com	1				perfor	rmed? death? 2 No 1 🗆 Yes	A.a
Vital	ysicien: Th is certificete director, pag	Be (	25. Was case referred to medical examiner?			26. Place o	of Death (Check only or		
OT O		은	1 ☐ Yes 2 No		ent 2 ER/Outpatie			dence 6 □Other (Spe	ecity)
	ding Phys h. After this funeral di	lo lo	27. Manner of Death 1 Natural 5 ☐ Pending		ay Year) 28b. Time of Injury	Work?		now injury occurred	
DIVISION	l or Attence efter death Diractor: in by the	licat	2 Accident investigation inves	ot be	jury - At home, farm, st			Street and Number or R	ural Route Number
2		Certification;	4 ☐ Homicide determin	building, et	ic. (Specify)	reet, factory, office	City or Tow		urar House Number,
	• Hospitel or 24 hours efte • Funerel Dir etely filled in		29a. Certifier 1 Certifying	Physician: To the best	of my knowledge, dear	th occurred at the time, date and	place, and due to the o	cause(s) and manner a	s stated.
	he Ho n 24 I he Fu oletely	ledical	(Check only 2 Medical E	xaminer: On the basis o and manner st	of examination and/or in	evestigation, in my opinion, death	occurred at the time, o	date and place, and du	e to the cause(s)
	To the lawithin 2. To the lacomplete	Σ	29b. Signature and title of celtifier	- 0 0	<b>*</b>	29c. License number		29d. Date signed (Mon	
	0/		De Ori	Riphr	W)	D3215	8	4/25/05	5
į-	11/		1 1 1	who completed cause of c	death (Item 23a) (Type	Print) Livhaw Street,	1 .1	0.4	
1	(		31. Date filed (Month, Day, Year)	alikh M?	X2/N.E	waw stellt,	sute 40]	, Baltino	ee, MD 21201
	Sta Registr	- 3		2 7 2005 A	California &	Soule			

DHMH 17 Rev 1/2001

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene O O C

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 2 3, 2003 8:55 PM CHARLES ROBERTSON ABRIL /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ST. AGNES NA HEALTH CARE BRLTIMORE If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth (Month, Day, 1 M 2 □ F Months 241.46.8821 68 NC Director 03 - 08 - 1937 Usual Residence of Decedent 10a State 10b. Counts 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "naturel", or Items 23a or 28a-f ehow traumatic event, the Medical Exam withmatics molified at 1 KYes 2 No NA BALTIMORE Director MD the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3709 SPRINGDALE AVENUE 21216 цŞА Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 版No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 KNo Specify: Specify: BLACK þ 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within 7 Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 1 EACHER 4 YRS BALTO. CITY SCHOOLS 12/1H GRADE 12 should be filed with and Mental Hygien 7 Is marked other th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) WALTER ROBERTSON BLANCHE MILLER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 s ment of Health an ant: If item 27 Is I ury or other trau ETHEL ROBERTSON 3709 SPRINGDALE AVE. BALTO, MD Date ) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department Important: If any injury or ARBUTUS 04.29.05 `4 ☐ Donation 5 ☐ Other (Specify) BALTO. MD 22. Name and Address of Facility
VAUGHN C. GREENE FUNERAL SERVICE 21. Signature of Funda I Service License 5151 BALTO. NATL' PIKE, BALTO MO 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician STROMAR Tumor GASTRO INTESTIMAL YEAR. /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transit and Due to (or as a consequence of): attending physician Box 68760 Physician/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 Other (specify) P.0. the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 Yes 2 No 3 Probably 4 Munknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 1 Tes 2 No of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2X No 1 Inpatient 2 ER/Outpatient 2 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Division 5 Pending investigation 1 Natural death. 1 ☐ Yes 2 ☐ No 2 Accident Director 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined or A 4 Homicide To the Hospitel within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 1)62023 M.D. APRIL 23: 2005 30. Name a d address of person who completed cause of death (Item 23a) (Type, Print) 900 CATON EMINCE M-3 tUENUE. BALTIMORE MD 21229. AYOBELE 31. Date filed (Month Day Year) 32. Registrar's Signature State And the Infine. Registrai

CHARL

ROBERISON

			1 - State of Marylan Registrar	-	artment of He tificate of De			ene 005	14298
			1. Decedent's Name (First, Middle, Last)				2. Date of Death Month		3. Time of Death
	Physicia /Medic		GEORGIA E. RHOE				APRIL 24		3:10 P M
	Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Lo	ocation of Death		4c. County of Deat	h
			BEVERLY HEALTHCARE CENTER		HAGERS	TOWN		WASHI	NGTON
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs.	last birthday)		f Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,		hplace (State or Foreign
	Director		220-16-1186 ¹□м 2Å F 96	Yrs.	World's Day's	110013	1/20/19	909 WES	ST VIRGINIA
	pu .		Usual Residence of Decedent  10a, State 10b, County 10c, Cfi	y, Town or Lo	eation				10d. Inside City Limits
	sho	5							1 ☐ Yes 2 ☑ No
	Ba-f	Director	WV BERKELEY	перые.	SVILLE				
	with t	늅	10e. Street and Number		10f. Zip Code 2542	7	10	g. Citizen of What Co	ountry?
	within 72 hours efter death with the Maryland ene. than "netural; or items 23a or 28a-f show he Medical Examiner must be multiled at	Funerai	4115 ALLENSVILLE ROAD  11. Marital Status 12. Was Decedent Ever in U	6 10 1				USA	den ladio
	item Item	Š	11. Marital Status  1 Never Mamed 2 Married  1. Was Decedent Ever in U Armed Forces?  1. Yes 2. Who	.5.	Was Decedent of Hisp f Yes, specify Cuban,	Mexican, Puerto	Rican, etc.)	14. Race - Ame Black, Whit	
5	rs of	by	3 XWidowed 4 Divorced Year or Dates:		1□Yes 2DÅNo .	Specity:		Specify:	WHITE
15-0036	tura	ed	15. Decedent's Education	16a, Dece	dent's Usual Occupation	on	1	6b. Kind of Business	
212	n "n	Completed	(Specify only highest grade completed)	(Give	kind of work done dur DO NOT use retired)		ng		
212	iene iene rtha	E	Elementary/Secondary (0-12) College (1-4or 5+)	HOM	EMAKER			OWN H	OME
<u> </u>	t Hygie other	Be C	17. Father's Name (First, Middle, Last)		18	B. Mother's Name	(First, Middle, M	aiden Sumame)	
Maryland	should be filed within 72 hours efter death with the Marylan nd Mental Hygiene. marked other than "netural", or flems 23a or 28a-f show imatic event, the Medical Examinar must be muffled at	To B	H. W. POOLE			ESTEL	LA BUTTS		
a <sup>2</sup>			19a. Informant's Name/Relationship (Type, Print)	19b. Mailir	ng Address (Street and	d Number or Rura	l Route Number,	City or Town, State, 2	Zip Code)
	and 2 sauth ar n 27 is ier treu		MAX B. RHOE/SON	411	5 ALLENSVI	LLE ROAD	, HEDGES	VILLE, WV	25427
ନ୍	es 1 and of Health f Item 27 r other tr			Place of Dispo	sition (Name of natory or other place)			0c. Location - City or	
Ë	Pages nent of int: If It		A Di buriai 2   Cremation 3   Removal from State	DER'S C		APRIL	2005	MORGAN CO.,	WV
Baltimore,	permit. Pages Department of Importent: If It any injury or once.		21. Signature of Funeral Service Licensee	22	. Name and Address	of Facility			
ñ	Person		Charles M. Brains		BROWN FUNERAL	L HUME, P. MÅRTİ	U. BOX 821 NSRURG WW	32/ W. KI	ING ST.,
			23a. Part1. Enter the disease, or complications that caused the deat shock, or heart failure. List only one cause on each line.						Approximate
	Physician		Immediate Cause (Final	00011	- 10 4	IN VA-C	.0	90:00	Interval Between Onset and Death
	/Medical		disease or condition resulting in death)  Due to (or as a consec		e Card	iv rosu	uero o	vouse	54-60ins.
	Examiner		Demen	+ 0					7 years.
		ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	uence of):					, , , , ,
	cuted	Examin	Cause (Disease or injury that initiated events						
ó	be executed siclen and burial-transit	Ě	resulting in death) Last Due to (or as a consec	uence of):					
8760	cete be executed physiclen and the burial-transll	dicai	d						
9		Jed	IF FEMALE:						
Вох	th ce tendi	an/l	23b. Was decedent pregnant 23c. If yes, outcome of pregnant		Ectopic pregnancy			23d. Date of del	,
	o dea	sici	1 Yes 2 No		Other (specify)			Month	Day Year
o.	at the	Physician/Me	9 Unknown						
Ś	Physicien: The law requires that the death certificate has been signed by the attending or this certificate has been signed by the attending rail director, page 2 should be deteched for use as	þ	Part II. Other significant conditions contributing to death but not res	ulting in the u	nderlying cause given	in Part I.		acco use contribute to	1.5
ב	w requir been si should I	ted					1 Tes	s 2 □ No 3 □ Pr	obably 4 Unknown
ပ္ပို	ne law r has be ge 2 sh	Completed					24a. Was an autopsy	24b. Were at	stopsy findings available completion of cause of
~	The ate h page	100					perform	egr/ death?	2 No
<u> T</u> a	iicien: Th certificate rector, pag	Be (	25. Was case referred to medical examiner?		2	6. Place of Death	(Check only one		
<u>~</u>	Phyeic this ce at dire	To		ER/Outpatier	t 3 DOA Other:	4 Nursing Hor	ne 5 🗆 Resider	nce 6 Other (Spe	cify)
Division of Vital Records,	Jing Pl J. After ti funera		27. Manner of Death 28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	t	28d. Describe how		
0	Attending or death. ector: After by the fune	ati	2 Accident investigation			s 2 No			
Ë	or Att ter de Irect	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At h building, etc. (Special Could not be determined 29c.)	ome, farm, str	eet, factory, office	1	28f. Location (Stre City or Town,	eet and Number or Ri State)	ural Route Number,
	rel C								
	To the Hospitel or Attending Phyeicien: The within 24 hours after death. To the Funerel Director: After this certificate hi completely filled in by the funeral director, page	Medicai	29a. Certifier  (Check only  2 ☐ Medical Examiner: On the basis of examinar	wledge, deatl	occurred at the time, vestigation, in my opin	date and place, a	and due to the car ad at the time, da	use(s) and manner as te and place, and due	stated. to the cause(s)
	the lin 2 the l	Ned	one) and manner stated.  29b. Signature and title of certifier						
)	Vit Cor	-	29b. Signature and title of certifier		29c. License n	F365	29	d. Date signed (Mont	n, Day, rear)
	•		manyar 1200-1			, /03	•	4.23.1	25.
	X		30. Name and address of person who completed cause of death (Iter			1 1 4	الم ما	N.4 -	. 15
				58 m	ell stree	1- Ha	gerston	n MD	21740
	Sta Registi		31. Date filed (Month Per Year) 7 2005 32. Signal 32. S	K A	and i		~		
	1.091311		MARION	~ /6/					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] [] 5 State Registrar amend item #18 per fh g842 495 Fige pf Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month **Physician** 41ex Rusabrov 1746 PM April 2005 22 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Baltimore City Snock Trauma Center 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1**X**]M 2□F Yrs. UKRAINE Director 213-39-5125 69 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes a No BALTIMORE REISTERSTOWN Direc 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20 REDMILE COURT U.S.A. 21136 by Funeral 14. Race - American Indian, Black, White, etc. WHITE 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 □ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 2 1 No 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 16b. Kind of Business/Industry during most of working College (1-4or 5+) Elementary/Secondary (0-12) INDUSTRIAL ENGINEER ENGINEERING 18. Mother's Name (First, Middle, Maic & Sumame) GOLOVANEVSKY 17. Father's Name (First, Middle, Last) RUSABROV GOLOVANRYSKY REBECCA MICHAEL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: if Item 27 is any njury or other trau 7901 VALLEY MANOR RD APT. E OWINGS MILLS, MD 21117 VICTORIA KRASNOVSKY / WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 04/26/2005 REISTERSTOWN, MD BALTIMORE HEBREW \* 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licensee 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 L. Kusser 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Due to (or as a consequence of): aceration /Medical Examiner vehicle Motor Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner CERTIFICATION APPROVED BY MEDICAL EXAMINER Due to (or as a consequence of): by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 No 2 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 □ No Certification: To 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred AVII 22, 2005 1545 PM 5 Pending investigation □ Natural Motor vehicle collision 1 Yes 2 No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number of Eural Route Number of Eural Route Number of Eurape 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 \ Homicide Street

allocation of the ording Physicien: The law requires that the death certificate be executed after death.

I Director: After this certificate has been signed by the attending physician and d in by the funeral director, page 2 should be detached for use as the burial-transit Box 68760 Division of Vital Records, P.O.

r than "natural", or items 23s or 28e-f ehow the Medical Examinar must be notified at

Pages 1 and 2 should be filed within 72 hours after death

ilth and Mental Hygiei 27 is marked other ti r traumatic event, the

Baltimore, Maryland 21215-0036

To the Hospital within 24 hours a To the Funeral C Hospital

filled in by

Medical

29a. Certifier

29b. Signature and title of certifier

State Registrar

Resident Physician 29c. License number

D0062664

1x Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

April 22,2005

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Morgen McCullowsh, MD

22 South Greene St. Baltimore, LO 21201

31. Date filed (Month, Day, Year)

32. Registra Signature

			1 - For State Registrar	State o	f Marylan		artmen rtificat			and M	lental Hyg	jiene	005	The state of the s	300
	81		1. Decedent's Name (First, Middle, L	.ast)	-						2. Date of Dea Month	th Day	Yeer	3. Time o	of Death
4	Physicia /Medic	_	James Smith									19, 20	05	6:45	PM M
	Examin		4a. Fecility Name (If not institution, g	ive street and nu	mber)				Location of			4c. County	of Death		
			3303 Ludgate			1 4 1. * 46 1. · ·	If Under		imore If Under		0 Day - ( Dist		0 8	1 (01-1-	
	Funeral		5. Social Security Number 6. 212–38–4485	Sex 1∭XM 2□F	7. Age (In yrs. 67	Yrs.	Months	Days	Hours	Min.	8. Date of Birth (Month, Day Feb 22,	1938	Cour	lece (State http) Land	or Foreign
	Director		Usual Residence of Decedent				1				100 22,	1730	1101.	, Lana	
	ylanc how		10a. State 10b. County		10c. Cit	ty, Town or Lo							1	0d. Inside C	
	e Ma-1 s	cto	MD			Baltin	nore								s 2 🗆 No
	ith th	Funeral Director	10e. Street and Number				10f. Zip				1	10g. Citizen of		ntry?	
	s 23a	rai	3303 Ludgate R		edent Ever in U	C 12	Was David		1215	sin2/Co	acity Vac or No.	14 Pa	USA ce · Americ	en Indian	
	ter de	nue	11. Marital Status  1 ☐ Never Married 2 ☐ Married	Armed F	orces?	.5. 13.	If Yes, spec	offy Cuba	n, Mexicar	n, Puerto	ecify Yes or No- Rican, etc.)	Bla	ck, White,		
99	urs af	b	3 ☐ Widowed 4 ☐ XDivorced	If Yes, G Year or D	ve		1 ☐ Yes	2⊠ No	Specify:			Specia	y: bla	ick	ĺ
Õ	be filed within 72 hours after death with the Maryland tal Hyglene. d other than "natural", or items 23a or 28a-f show avent, the Medical Examinar must be notified at	Completed	15. Decedent's (Specify only highest of			16a. Dece	dent's Usua kind of wo	al Occupa	ation	t of work	ina	16b. Kind of B	usiness/In	dustry	
2	ithin le.	npie	Elementary/Secondary (0-12)	College (	1-4or 5+)	life.	DO NOT u	se retired,	)				_		
2	filed w Hygier ther th		17. Father's Name (First, Middle, La	0			fore	nan	18 Moths	ar's Nam	e (First, Middle,	Maiden Suma	foo	d	
and	Mental H Mental H arked ot atic aver	Be	Jerry Smith	51/							rie Smit		ne)		
Maryland 21215-0036	should and Men amarke umatic	ဥ	19a. Informant's Name/Relationship	(Type, Print)		19b. Mailii	ng Address	(Street a			al Route Number		, State, Zip	Code)	
Ma	and 2 sealth ar n 27 is		April Smith/dau			330	3 Lud	rate	Road	l Bal	ltimore,	MD 21	215		
re,	of Health item 27		20a. Method of Disposition			Place of Dispo	sition (Nar	ne of	- !		Date	20c. Location	- City or To	wn, State	
Ē	Pages nent of int: If it		1 ☐ Burial 2 ☐ Cremation 3  `4 ☐ Donation 5 🖾 Other (Spe		State										
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Menial Hygiene. Department of Health and Menial Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic avent, the Mudical Examiner minut be notified at ODGs.		21. Sign. ture of Funeral Service Lio KONA	ensee Wade	igesto	r Š	Name ar tate altim	d Addres Anato	omy B	oard 2120	655 W.	Baltim	ore S	Street	:
-	*		23a. Part 1 Enter the disease, or co shock or heart failure. List or	mplications that	caused the dear	th. Do not en	ter the mod	e of dyin				rest,	F	Approxima Interval Be	etween
	Pnysician	8 1	Immediate Cause (Final disease or condition	.,	Myor	ardsol	int	direct	Lim	( by	cobuble			Onset and	Death
1	/Medical Examiner		resulting in death)	Due to	(or as a consec	quence of):		21.50	1	7	- Kanada A		-		ALARU, C
	Examiner	_	Sequentially list conditions,	b. — Due to	(or as a consec	try (A)	+21	4 T	MON	npol	13		-	1 hims	diate,
	ted	nlne	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due 10	Mr. Her	100010	- 14	6	1-11	. V.I	I LIA LA IN	131	CB.10	1111/	00 10
	be executed ician and burial-transit	Examiner	that initiated events resulting in death) Last	c Due to	(or as a consec	quence of):	rong		evi uni	UVU	o cvila v	an	CN(0)	_ MIII	WW.
760,	eath certificate be executed attending physician and for use as the burial-transit	cai		d											
89	tificat ng phy as th		IS SEALAL S.												
Вох	th cer tendir	an/h	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?		itcome of pregn birth 2 Feta		⊒Ectopic pi	egnancy					ate of delive	ery Day	Year
	The law requires that the death certifical to has been signed by the attending phyage 2 should be detached for use as the	Physician/Med	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Preg 9 ☐ Unki	nant at time of one	death 5	Other (sp	ecify)				1			
P.O.	that the od by detac	Phy	Part II. Other significant condition	s contributing to	death but not res	sulting in the u	inderlying o	ause give	en in Part I		23e. Did to	bacco use con	tribute to the	ne cause of	death?
ds,	w requires that been signed to should be deta	d by	diabetes n	12/1/64	(						<b>1</b> □¥	'6s 2 □ No	3 🗆 Prob	ably 4	]Unknown
COL	w req	lete									24a. Was a	an 24b.	Were auto	psy finding: mpletion of	s available
Vital Records,	The law ate has page 2 s	Completed									autop perfor	med?	prior to co death? 1 Yes		cause of
ta		0	25. Was case referred to medical	No					26. Place	of Deat	h (Check only or			20110	
		To B	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1	Inpatient 2	ER/Outpatie	nt 3 🗆 DC	Othe	er: 4□Nu	ursing Ho	ome 5 Resid	lence 6 🗆 Ot	her (Specif	y)	
n of	Ing Pl		27. Manner of Death 1 ☐Natural 5 ☐ Pending	28a. Date (Mo	of Injury oth, Day Year)	28b. Time o Injury		8c. Injun Worl	k?		28d. Describe h	ow injury occu	rred		
sio	Attending r death. ector: After by the fune	cati	2 Accident investiga 3 Suicide 6 Could no	t be	a of Initial At h		М		Yes 2 🗌	No	28f. Location (S	Street and Num	her or Dur	J Douto Nu	mhar
Division	tel or Al	Certification:	4 Homicide determin	ed 286. Plac build	e of Injury - At h ling, etc. (Speci	ify)	reet, factor	у, апісе		ļ	City or Tow	m, State)	Der OF FUT		11001,
	To the Hospitel or Attending Phys within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral di	edical (	29a. Certifier 1 Certifying (Check only one) 2 Medical E:	Physician: To the caminer: On the and ma	e best of my kn basis of examin nner stated.	owledge, dear ation and/or in	th occurred nvestigation	at the tim	ne, date ar pinion, dea	nd place, ath occur	and due to the d red at the time, o	cause(s) and m date and place	anner as s and due to	tated. the cause	(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	A	C 0		29	c. License	e number			29d. Date sign	ed (Month,	Day, Year)	
•			Mun	tail's	July	nn	0	1)	532	12		4	121	105	
			30. Name and address of person w	ho completed car	se of death (Ite	m 23a) (Type	Print)		. 4	·	1		, /		
	-01		31. Date filed (Month, Day, Year)	1 1 1 30°	Registrar's Sign	ature	00 6	ape	Rd	[ (1	tonsul	IS MO	1-1-1	22+	
	Sta Regist			005	in b	Los	de								

			For State Registrar	State of Maryland	/ Depa	ırtment o			•	14301
	Physici /Medio	al		4 R. SCOT	7	41. C'h. T.		2. Date of Death Month APPIC	Day Year	5 0354 M
	Examir Funeral Director	ier	5. Social Security Number 6. Se	NOEL HOSP.		If Under 1 Ye Months Da				
	iges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene.  If Item 27 is marked other then "naturel", or Items 23s or 28e-f show or other treumatic event. The Medical Exameration was the collised at	Funeral Director	10e. Street and Number  4204 4th Street  11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	oklyn	Park 10f. Zip Coo	.225		g. Citizen of What C USA 14. Race - Am Black, Wh	10d. Inside City Limits 1 ☐ Yes 2 ☆ No  Country?
21215-0036	within 72 hours afte iene. then "naturel", or li iiu Medical Evant	Completed by Fi	1 Never Married 2 Amarried 3 Widowed 4 Divorced  15. Decedent's Ed (Specify only highest grade) Elementary/Secondary (0-12)  12.	College (1-4or 5+)	6a. Deced (Give i life. L	ent's Usual Ocklind of work do	cupation most of tired)	working 16	Specify: 1	White
Maryland 2	12 should be filed within "h and Mental Hygiene. 7 is marked other then "ireumatic event, the Mes	To Be Co	17. Father's Name (First, Middle, Last)  Harold Maile  19a. Informant's Name/Relationship (7				Fra	Name (First, Middle, Mances G - Pee	ery	
Baltimore, M	F F F		Charles Scott— S  20a. Method of Disposition  1 XBurial 2 Cremation 3   1 Donation 5 Other (Specify	20b. Place ceme	of Dispositery, crem Meado	sition (Name of natory or other DWridge Park	place)	4/25/2005 E	oc. Location - City o	MD
Balt	permit. Pag Department Importent: I eny Injury o		21. Signature of Funeral Service Licen:				dress of Facility dge Memo ington B	Gary L Kau rial Park Ivd., Elkri	fman Fund Inc. age; MD 2	eral Home at 21075
,092	Physician /Medical Examiner  portion and p	i Examiner	23a. Part1. Enter the disease, or comp. shock, or heart failure. List only of immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as a consequence	L19 ce of): ce of):	18 CP11	DIAL	INFIGRA DISGIASE		Approximate Interval Between Onset and Death
P.O. Box 687	ath certificate ttending phy or use as the	Physician/Medicai	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	d	ath 3 🗌	Ectopic pregna Other (specify			23d. Date of de Month	slivery Day Year
	w requires that the de- been signed by the a should be detached fo	by	Part II. Other significant conditions of	ntributing to death but not resulting CRENAU  DIAU	g in the un	derlying cause	given in Part I.			to the cause of death?
al Records,	ilcien: The law r certificate has be rector, page 2 sh	Completed		Dialy	151.	5			prior to	utopsy findings available completion of cause of s
ion of Vital	anding Physicien: The ath.  or: After this certificate hate funeral director, page	ation: To Be	27. Manner of Death 1 Matural 5 Pending 2 Accident investigation	Hospital: 1 Inpatient 2 ER/ 28a. Date of Injury (Month, Day Year) 28t	Outpatient o. Time of Injury	28c. li		Death (Check only one)  g Home 5 Residence 28d. Describe how	ce 6 Other (Speinjury occurred	acify)
Division	To the Hospitel or Attending within 24 hours after death.  To the Funerel Director: After completely filled in by the fune	al Certification:	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined	28e. Place of Injury - At home, building, etc. (Specily)	lge, death	occurred at the	e time, date and pla	City or Town, s	State) se(s) and manner a	iural Route Number,
į	To the Ho. within 24 h To the Fur	Medical	(Check only 2 Medicel Exemple)  29b. Signature and title of certifier  30. Name and address of person who compared to the comp	Iner: On the basis of examination and manner stared.  ATHUMENTER	and/or inv	estigation, in m	ense number	ccurred at the time, date	e and place, and du	e to the cause(s) th. Day, Year)
	Sta Registi	_	Carlos Patalino 31. Date filed (Month, Day, Year)	hug, 3721 Po	Speed	Street	, Suite 6	, Balto., N	4D 21225	

		1	For State Registrar	State of Ma	ryland / [		ent of Hea		Mental Hy	giene	05	14302
Phys	sicia:	n	Decedent's Name (First, Middle, La	S C C	OFI	ELD	5 5 4	2.	2. Date of De Month		Year 2005	3. Time of Death
1	mine		a. Facility Name (If not institution, git BUN SE COUL	ve street and number) RS HOS	PITA	46.0	3 ALT	T MO	ith 1 RE	4c. Coun	ty of Death	
Funei Direct	_	2	,	- TT -	In yrs. last bir	Yrs. If Ur		f Under 24 Hr Hours Mir		rth ay, Yea <i>r)</i> - 1914	9. Birthpi Coun	lace (State or Foreign try) SC
death with the Maryland ims 23a or 28a-1 show		1	Oa. State 10b. County		10c. City, Tow						11	0d. Inside City Limits 1 X Yes 2 □ No
with the		Direc	0e. Street and Number 3213 BRIGHTON	STREET			Zip Code			10g. Citizen of	f What Coun	try?
ie ie		by Funer	1. Marital Status  1. Never Married 2 Married  3. Widowed 4. Divorced	12. Was Decedent E Armed Forces? 1 6 Yes 2 N If Yes, Give Year or Dates:		If Yes,	ecedent of Hisp specify Cuban, i	anic Origin? ( Mexican, Pue Specify:	Specify Yes or N rto Rican, etc.)	0- 14. Ra	ace - Americ ack, White,	etc.
1d 21215-0036  I filed within 72 hours af all Hygiene. other than "natural", or yent, the Medical Experience.		Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)			(Give kind o	Jsual Occupation work done during the retired)	ing most of w	orking Vatov	16b. Kind of	Business/Inc	dustry
Maryland 2 Maryland 2 Md 2 should be filed the and Mental Hygi 27 is marked other traumatic event.		e e	17. Father's Name (First, Middle, Las	t)				3. Mother's Na	ame (First, Middle NEWMAI	e, Maiden Suma	ame)	
e, Mary 1 and 2 sho Health and em 27 is man			19a. Informant's Name/Relationship VELMA SCOFIELD	(Type, Print)	32		RIGHTON	~~	BALTO, Date		1216	
Baltimore, permit. Pages 1 a Department of Her Important: If item any Injury or othe			20a. Method of Disposition  1	ify)	CRESI	ry, crematory LAWN	or other place)		28.05	MARRIC	ત્રાહેતાન	
Depariment of the period	8000		Vange (	7	the death Do	5151	BALTO. 1	VATL P	FUNERAL IKE, BA	40. MI	E 212	29 Approximate
8760, Medicise be executed Examin physician and the burial-transit the burial-transit	eal ner	aminer	23a. Part1. Enter the lisease, or conshock, or leart failure. List only immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a c. SE	e. TE a consequence OS T a consequence E P T a consequence	REN Af	IAL IC EM	FA	ANC	RE		Interval Between Onset and Death
Box 6 ath certific attending p	5	¥e	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal death	n 3□Ectop 5□ Othe	ic pregnancy (specify)				Date of delive Month	o <b>ry</b> Day Year
rds, P.O. quires that the de n signed by the and the detached		ρ	Part II. Other significant conditions	contributing to death bu	ut not resulting i	in the underly	ng cause given	in Part I.		tobacco use co Yes 2 □ No		e cause of death?
	Daga V	Completed							24a. Wa auto peri 1 □ Yes	opsy formed?	o. Were autoprior to condeath? 1 ☐ Yes	psy findings available inpletion of cause of
on of Vital F Jing Physician: Th After this certificate		S B	25. Was case referred to medical examiner?  1   Yes   2   No  27. Manner of Death 1   Natural   5   Pending	Hospital: 1 atie 28a. Date of Injur (Month, Day	y. 28b.	utpatient 3 Time of Injury	DOA Other: 28c. Injury at Work?	4 Nursing	eath (Check only Home 5 Res 28d. Describe	525 EST		()
or Attendated of Attendated of Attendated of Sirector:	an yan b	Certification:	2 Accident investigati 3 Suicide 6 Could not 4 Homicide determine	be as Blace of Inju	ury - At home, fa c. (Specify)			2 2 3		(Street and Num own, State)	mber or Rura	l Route Number,
DIVI To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	pletery me	edical		Physician: To the best of aminer: On the basis of and manner sta	examination ar		tion, in my opin	ion, death oc		, date and place	e, and due to	the cause(s)
Tot	600	Σ	29b. Signature and title of our filer	R. Cri	12 m	u.)	29c. License n	0 3 0	355	29d. Date sign	led (Month, )	Day, Year) Y, 2005
(	1		ROSITA 1	ampleted cause of d	eati (IV m 23a)  LJ Z  ar's Signature	(Type, Print)	D	Boi	4 51	ECO	UR	S
Rec	Stat gistra	_	31. Date filed (Month Cay, Year)	2005	ar s digitatilite	Sport	3				40	Spilal

			1 - For Stata Registrar		State of	Marylar		artmen			and Me	ental Hyg	iene ()	05	14303
	Physici	an	1. Decedent's Name (								2	2. Date of Deat Month	h Day	Year	3. Time of Death
	/Medic	al	EVA		RRAINE		4ITH					April	23	20	/230
	Examin	er	4a. Facility Name (If n	ot institution, g	ive street and numb	oer)	10/10	4b. City,	Town, or	Location	of Death			y of Death	
			5. Social Security Nun	KIGUOTI	Sex 7	Ann In urs	Iast birthday	) If Under	1 Year	If Under	24 Hrs   6	3. Date of Birth	N	conic	
	Funeral Director		213-24-245		1□M 2⊠F	76		Months	Days	Hours	Min.	(Month, Day, une 14,	Year) 1928	Mary.	
			Usual Residence of D								Ψ	une 14/	1020	racy.	Land
	rylen how		10a. State	10b. County		10c. Ci	ty, Town or L	ocation						10	d. Inside City Limits
	Ba-f e	cto	Maryland	Somer	set				Cri	isfie	ld				12 Yes 2 □ No
	or 2	Director	10e. Street and Numb					10f. Zip				10	0g. Citizen of		ry?
	s 23s		265 S. Sc	omerset		- Francis II	1.6			21817	1-0-(0	4		USA	- I - d' -
	Itam Itam	Funerai	11. Marital Status 1 ☐ Never Married	1 2 Married	12. Was Deced Armed Ford 1 ☐ Yes 2	ent Ever in U :es? :XINo	1.5.	If Yes, spec	ent of Hi	n, Mexicar	gin? (Spec 1, Puerto Ri	ify Yes or No- ican, etc.)		ce - America ack, White, e	etc.
99	urs af	by	3 ₩ Widowed 4	_	If Yes, Give Year or Dat			1 ☐ Yes 2	No XS	Specify:			Speci	ty: T	White
Ö	filed within 72 hours after deeth with the Marylend Hygiene. sther then "natural", or Itams 23s or 28s-f ehow ent, the Medical Examinar must be notified at	Completed by	(5-22)	5. Decedent's	Education		16a. Dece	dent's Usua	I Occupa	ation	t má sun deine		16b. Kind of E	Business/Ind	ustry
2	thin 7 8. 8. "r	ed l	Elementary/Second		rade completed) College (1-4	lor 5+)	life.	kind of wor DO NOT us	se retired	<i>juring</i> mos	t of working	7	Cloth	ing	
7	ed wil	S	12					Seam	str					actur	er
<u>n</u>	tel H	Be	17. Father's Name (Fi									First, Middle, N	faiden Suma	me)	
$\frac{1}{2}$	should be nd Mentel marked c	ဥ	Edward Hu				401 14 11		(0)		a Wha				
Maryland 21215-0036	d 2 st th and 7 le n treun		19a. Informant's Nam Ellen Hol	•								Route Number, incess			
	permit. Pages 1 end 2 should be filed within 72 hours after deeth with the Marylen Department of Heelth and Mentel Hygiene. Importent: If item 27 is marked other than "natural", or itams 23a or 28a-f show any injury or other treumatic event, the Medical Examinat must be notified at once.		20a. Method of Dispo		Daugiteer /	20b. i	Place of Disp cemetery, cre		_		Da		20c. Location		
lo lo	Pages nent of I ont: If it		1 ØBurial 2 ☐ '4 ☐ Donation 5		Removal from St	alo				1	'1 00				
Baltimore,	ertme orten Injur		21. Signature of Fune			Sun						5, 2005 C		ela, Ma	aryland
Ba	permit. Depertr Importe any Inju		May	Beth	Bladslaw	Thu						eral Ho - Crisf		MD 21	017
			23a. Part1. Enter the	disease, or co	adshaw-Pr mplications that cau ly one cause on eac	used the dea									Approximate Interval Between
	Priysician		Immediate Cause (Fi		Tr	Men S	MIT	M	604	1/1	Mer	1515			Onset and Death
	/Medical		resulting in death)	4	aDue to (o	r as a consec	quence of):	12	207	6	N LZIA	13/2_		-	-
	Examiner		Sequentially list cond	fitions	b										
	σ ##	Iner	Sequentially list cond if any, leading to imm cause. Enter Underly	nediate /ing		r as a consec	quence of):								
2	ecute and trans	Examiner	Cause (Disease or in that initiated events resulting in death) La	Jury 🌇	C. Due to (e	r as a consec									110
8760,	ate be executed thysicien and the burial-transit	E E	<b>3</b>		0) 01 800	as a consec	querice or).								
	physicate	dical			d			-							
9 X	deeth certific: e ettending pl ed for use as t	by Physician/Me	IF FEMALE: 23b. Was decedent p	regnant	23c. If yes, outco								23d. Da	ate of deliver	v
Вох	deeth e etter	ciar	in the past 12 m	onths?		th 2 Feta nt at time of o		⊒Ectopic pro □ Other (spe							Day Year
o.	t the c	hys	9 ☐ Unknown		9□ Unknow	m									
ď	wrequires that the deeth been signed by the ette should be detached for	Jy P	Part II. Other signific	ant conditions	contributing to dea	th but not res	sulting in the	underlying ca	ause give	en in Part I		23e. Did tob	acco use con	tribute to the	cause of death?
ğ	aquire an slo	ed	Ellen	DISFI	USEN 4	An	Bort	1				1 □ Ye	s 2□No	3 Proba	bly 4 □Unknown
900		Completed	Arnes	1 P	Drang	TEO						24a. Was an		Were autop	sy findings available pletion of cause of
Œ	Thate ate	Com										perform	ed?	death? 1 ☐ Yes 2	•
/ita	iclen: Th certificate rector, pag	Be (	25. Was case referre	d to medical							of Death (	Check only one	9)		
of Vital Records,	Physiclen: r this certific ral director,	2	1 □ Yes 2/0 N	0			ER/Outpatie			4 🗆 140		9 5 ☐ Reside			
ň	After unerg	ion:	27. Manner of Death  1. Natural	5 Pending		Day Year)	28b. Time of Injury		Bc. Injury Work	(?		d. Describe ho	w injury occu	rred	
isi	death. ctor: A y the fu	icat	2 ☐ Accident 3 ☐ Suicide	investigat	h =	f Injune - At h	iomo form el	M factors		Yes 2 🗌		f. Location (Str	met and Num	har or Pural	Pauta Number
Division	l or Attending efter death. Director: After i in by the funer	Certification:	4 Homicide	determine	building	, etc. (Speci	iome, farm, st	rest, factory	, once		20	City or Town		Dei Or Hurai	noute vulliber,
The same of	To the Hospital or Attanding Phwithin 24 hours efter death. To the Funeral Director: After th completely filled in by the funeral		29a. Certifier 1	Certifying	Physician: To the b	est of my kn	owledge, dea	th occurred a	at the tim	e. date an	d place, an	d due to the ca	use(s) and m	anner as sta	ted.
	HO 124 h	edicai	(Check only 2 one)	☐ Medical Ex	aminer: On the bas and manne	is of examina	ation and/or in	vestigation,	in my op	oinion, dea	th occurred	I at the time, da	ite and place,	and due to	the cause(s)
	To the Hospital within 24 hours e To the Funeral Completely filled	Me	29b. Signature and tit	e of certifier	è					number			d. Date signe	ed (Month, D	lay, Year)
	Λ		16	the				10	100	46	080	)	4/23	105	-
	1		30. Name and address	s of person wh	o completed cause			, Print)							
	'		Rubert		se mi		100 EC	anol	127	reet	Sal	ber	nel	2180	1
	Sta Registi		31. Date filed (Month	PR 2 7	2005	gistrar's Sign	ature	and a					,		
						THE -	AST AND	1							

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State	State of Marylan		ment of H		•	-	2000	11001
			Registrar  1. Decedent's Name (First, Middle, Last)		Octun	Cate Of L	Jean	2. Date of De	Reg. No. ath	. 0.00	3. Time of Death
	Physici /Medi		LUKE			AIRE		Month	Day	ò55	01:250
	Examir Funeral	ner	4a. Facility Name (If not institution, give s SHADY GROVE  5. Social Security Number 6. Sex	ADVENTIST F	ast birthday) If	COCKV	Location of Deat LLE If Under 24 Hrs	MARYLE	h)		TGOMERY thplace (State or Foreign
	Director		NONE 12	(M 2□F Ø	Yrs. Mo	onths Days	Hours 34	(Month, Da	y, Year)	5 M	ARYLAND
	Maryland	tor	10a. State 10b. County  MD MONTG		, Town or Location						10d. Inside City Limits 1 XYes 2 ☐ No
	with the	Direc	10e. Street and Number	0	1	Of. Zip Code	3-1		10g. Citi	zen of What C	ountry?
	ems 23	Funeral Director		AVENUE  12. Was Decedent Ever in U. Armed Forces?	S. 13. Was	Decedent of His	spanic Origin? (S	Specify Yes or No to Rican, etc.)	-	14. Race - Am Black, Whi	
920	ours after ai', or its Examin	वि	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 X No If Yes, Give Year or Dates:		Yes 2 No	Specify:	,,		Specify: Bl	LACK
1215-0036	within 72 hours after death with the Maryland ane. than "natural", or items 23s or 28s-f show is Medical Examiter coast be ricilified at	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)		life. DO N	s Usual Occupa of work done di NOT use retired)	luring most of wo	rking	16b. Ki	nd of Business	Vindustry
Maryland 21	be filed tal Hygi d other svent, t	To Be Co	17. Father's Name (First, Middle, Last)  LUKE ST. CL	AIR				ne (First, Middle,	Maiden	20 -	NE
_	1 and 2 should Health and Men Iem 27 is marke		19a. Informant's Name/Relationship (Ty). Jennifer St. Clair	e mother	301 8	Bradle	nd Number or Ri	ROCKUI	le r	nd 2	0851
altimore,	Pages 1 ient of H int; if ite iry or oth		20a. Method of Disposition  1   → Burial 2 □ Cremation 3 □ R  1 □ Donation 5 □ Other (Specify)	emoval from State	lace of Disposition  emetery, cremato  te of	ry`or other place	1	Date 6 / 2005		ation - City o	Town, State
Balti	permit. Page Department of Importent; if any injury or once.		21. Signatury of Funeral Septice United			LTPAddes	: Kînali	I FUNE	RAL	SERVI	CE,P.A. .ng,Md20910
	Pnysician	2 21	23a. Part1. Enter the disease, or complishock, or healt failure. List only on Immediate Cause (Final disease or condition resulting in death)	cations that caused the death le cause on each line.	1 3	e mode of dying	, such as cardia	or respiratory a	rrest,		Approximate Interval Between Onset and Death 34 MM.
8760,	cate be executed physician and the burial-transit	dicai Examiner	Sequentially list conditions, it any, leading to remission cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	ue to (or as a consequ	uence of):	phire	9 n	rembr	ar	re	I day 18tr. 55
.O. Box 68	The law requires that the death certifica tile has been signed by the attending phoage 2 should be detached for use as the	by Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 M No 9 □ Unknown	3c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de	death 3 Ect	opic pregnancy ner (specify)			2	3d. Date of de	livery Day Year
Q.	juires that t n signed by ild be detac	d by Ph	Part II. Other significant conditions con	ntributing to death but not resu	ulting in the under	lying cause give	n in Part I.		obacco u Yes 2	u.	o the cause of death?
al Records,		Completed						24a. Was autor perio 1 X Yes		24b. Were a prior to death?	utopsy findings available completion of cause of
Vital	Physician: r this certific ral director,	Be	25. Was case referred to medical examiner?	lospital:		Othe	pre-	ath (Check only o			
of	ng ffei	lon: To	27. Manner of Death  1. Natural 5 Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work	at ?	lome 5 Residence 1			ocify)
Division	Atten	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At he building, etc. (Specify	me, farm, street,		′es 2 □ No	28f. Location (8 City or Tox	Street and vn, State,	d Number or R	ural Route Number,
	To the Hospital or within 24 hours after To the Funeral Dircompletely filled in	Medical C	29a. Certifier (Check only one) 1 Certifying Phys	sicien: To the best of my kno- ner: On the basis of examinal and manner stated.	wledge, death occition and/or investi	curred at the time gation, in my op	e, date and place inion, death occu	e, and due to the arred at the time,	cause(s) date and	and manner a place, and du	s stated. e to the cause(s)
	To the To the Complex complex	Me	29b. Signature and title of certifier			29c. License	number		29d. Dat	e signed (Mon	th. Day, Year)
			1 Olm				627		4/	15/2	005
			30. Name and address of person who co SGAH, 9901 Med	lical Center [	Inve R	·	e mo	2085	0		
	Sta Regist		31. Date filed (Month, AP 1922 7 2	32. Redistrar's Signa	ture	and I					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. No. 2. Date of Death 1 Decedent's Name (First, Middle, Last) 3. Time of Death Day Year **Physician** 8:30 P AWSON PAIL 22 2000 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE 105 Cours If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Hours Min. (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Birthplace (State or Foreign Country) **Funeral** 1 ∰ M 2 □ F Months 239-46-967 Yrs. Director Usual Residence of Decedent the Maryland 10b. County 10c. City. Town or Location 10d. Inside City Limits 10a. State permit. Pages 1 and 2 should be filed within 72 hours alter death with the Maryla Department of Health and Mental Hygiene. Important: if itam 27 is marked other than "natural", or Itams 23a or 28a-f show any injury or other traumatic event, it is Medical Eventifier must be notified at once. Yes 2 No Director W AMUYE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3715 21215 OWN Funerai 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 M No If Yes, Give Year or Dates: 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 207 Married Specify: Black Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Stone abover 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Unknown 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3711 Listerston 20b. Place of Disposition (Name of 20a. Method of Disposition cemetery, crematory 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Zion \* 4 ☐ Donation 5 ☐ Other (Specify) RM 21. Signature of Funeral Service License Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that shock, or heart failure. List only one cause on ea used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medicai Examiner or Attanding Physician: The law requires that the death certificate be executed burial-transit the attending physician and hed tor use as the burlat-tran Due to (or as a consequence of): use as the IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) D.O. page 2 should be detached 9 Unknown 9 🗌 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Junknown Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 1 Yes 2 No director. Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Impatient Certification: To 1 ☐ Yes 2 ☐ Mo 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) tuneral 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Atter Natural 5 Pending 1 Tes 2 No within 24 hours after death. To tha Funaral Director: A investigation 2 ☐ Accident the t 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 29a. Certifier 1 🗲 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of cedifier

State Registrar 31. Date filed (Month, Day, Year) 32. Registrar's Sign

APR 2 7 2005

30. Name and address of person who completed

KUSII

2. Régistrar's Signature

ORIGINAL

(Hem 23a) (Type, Print)

			For State Registrar	State o	f Marylan		artment tificate			and M	lental Hy	giene Reg. No ?	n E	11.	200
			1. Decedent's Name (First, Middle, La	•							2. Date of De		Year	3. Time of	Death
	Physicia /Medic		Ella Louisa Winstor	Strother	:						April 22	•	1601	1:10	A M
	Examin		4a. Facility Name (If not institution, give	e street and nur	nber)		4b. City, To			of Death		4c. Count	y of Death		
			2702 Lyndhurst Avenu 5. Social Security Number 6. S		7. Age (In yrs. I	net hirthday)	Ba If Under 1	1tim	ore If Under:	24 Hrs	0 Date of Bi	rth.	NA O Fint	-1	Familia
	Funeral Director			_M 20 <b>X</b> F	90	Yrs.		Days	Hours	Min.	January	th 31, 1915	Virg	place (State o intry) inia	or Foreign
			Usual Residence of Decedent										V116	LILLI	
	rylen thow		10a. State 10b. County		10c. City	, Town or Lo								10d. Inside C	
	Be-f	Director	MD NA			Balti									2 □ No
	death with the Marylend ms 23e or 28e-f show r must be rotified at		10e. Street and Number				10f. Zip C					10g. Citizen of		intry?	
	s 236	erai	2702 Lyndhurst Ave	· · · · · · · · · · · · · · · · · · ·	edent Ever in U.	9 12 1		216	spanie Orie	ain? /Sn	noity Voc or No		JSA	ican Indian,	
	fter d	Funeral	1 Never Married 2 Married	Armed Fo	rces?				n, Mexican	, Puerto	ecify Yes or No Rican, etc.)	Bi	ack, White		
3	al', o	ρ	3 ☐ Widowed 4 🛣 Divorced	If Yes, Giv Year or D	'e		1 ☐ Yes 2[	XNo	Specify:			Spec	ity: Blac	ck	
213-0030	72 hc netur	eted	15. Decedent's Ed (Specify only highest gra	ducation de completed)		(Give	dent's Usual kind of work	done d	uring most	t of work	ing	16b. Kind of	Business/Ir	ndustry	
	be filed within 72 hours after death with the Marylen Hygiene. de thy typen. de thy then "netural; or ttems 23e or 28e-f show event, its Marical Exertinat must be notified at	Completed	Elementary/Secondary (0-12)	College (1	-4or 5+)	life. I	00 NOT use Teache					Pub1	ic Scho	201	
2 0	Hygie Hygie ther I		17. Father's Name (First, Middle, Last,	)			TCACIC	-1	18. Mothe	er's Name	e (First, Middle	, Maiden Suma			
<u>a</u>	should be nd Mental marked c	To Be	Frank C. Winston						E11a	Scot	tt				
Maryland		_	19a. Informant's Name/Relationship (	Type, Print)		19b. Mailir	ng Address (	Street a				er, City or Town	, State, Zi	p Code)	
	and 2 ealth a m 27 ls		Evelyn Strother/ Daugh	iter		2702	Lyndhur	st A	venue	Balti	imore, M	21216			
ващтоге,	of He		20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □	Removal from		lace of Dispo emetery, crer	sition (Name natory or oth	of er place	9)	[	Date	20c. Location	- City or T	own, State	
	t. Pag tment tent: tjury o		* 4 □Donation 5 □ Other (Specif	y)		nel AME				-29-(	)5	Hampton	, VA		
מ	permit. Pages 1 Department of H Importent: If Ite any injury or ot once.		21. Signature of Funeral Service Lice	see	)		2. Name and				7 0:1		n.1	MD 0101	7
			23a. Part1. Enter the disease, or com	olications that of	aused the death							Street ]	salto,	Approximat	te
	Dhysisian		shock, or heart failure. List only Immediate Cause (Final	one cause on e	ach line.		A .							Interval Bet Onset and	
	Physician /Medical		disease or condition resulting in death)	a Due to	or as a consequ	uence of):	4749	222	0,0	إكسوللج	30			754	15
	Examiner		Sequentially list conditions,	b		,									
	ii od	iner	any, leading to immediate cause. Enter Underlying	Dus to	or as a consequ	usinos or).									
	be executed iclen and burial-transit	Examin	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to	or as a consequ	uence of):							-		
/e0,	ate be executed hysiclen and the burial-transit	ical E		_	(0. 00 0 0 0 0 0 0 0 0										
28	ficate physics the			_ 0	_	-						1			
ŏ	The law requires that the death certificate tte has been signed by the attending phys age 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant		come of pregna		TEstania aras	ananou.				23d. D	ate of deliv	very	
מ	deatl	sicia	in the past 12 months? 1 Yes 2 No		ant at time of de		]Ectopic pred ] Other (spec					N	onth	Day '	Year
J.	at the ded by the detached	Phy	9 Unknown			Mr. C. M					02- Did				d4b-0
js,	uires thai signed t Id be det	by	Part II. Other significant conditions	LINSU	1	-	nderlying cat	126 Give	in in Paπ I. -			tobacco use cor		bably 4 🗆	
Ö	w requ	etec		. /		1	z i reevi	V , (C							
Hecords,	The lav	Completed	consentive of	eux 12	nwe,	- 44	There	evv.	sion		24a. Was auto perf	psy ormed?	prior to co death?	opsy findings ompletion of c	ause of
VITAI		e Co	25. Was case referred to medical						26 Place	of Deat	1 Tes	2 No	1 🗆 Yes	2 No	
	Physicien: r this certifica ral director, p	o B	examiner? 1 ☐ Yes 2 █ No	Hospital: 1	Inpatient 2	ER/Outpatier	nt 3 DOA	Othe				idence 6 🗆 Ot	her (Speci	ify)	
10 C	ding Ph h. After thi funeral	n: T	27. Manner of Death 1 ■Natural 5 □ Pending	28a. Date (Mon	of Injury th, Day Year)	28b. Time o		c. Injury Work	at			how injury occu			
<u> </u>	endir eath. or: Al the fu	catic	2 Accident investigation	n			М		res 2□	No					
DIVISION	or Ati	Certification:	3 Suicide 6 Could not be determined	280. Place	of Injury - At ho ng, etc. (Specif	ome, farm, sti y)	reet, factory,	office			28f. Location ( City or To	Street and Num wn, State)	ber or Rur	al Route Num	iber,
_	To the Hospitel or Attending within 24 hours after death.  To the Funerel Director: After completely filled in by the fune		29a. Certifier 1 Certifying Pl	vsician: To the	best of my kno	wledge deat	h occurred at	t the tim	e, date an	d place	and due to the	cause(s) and n	nanner as	stated	
	e Hos	Medical	(Check only 2 Medical Examone)	miner: On the b	asis of examina ner stated.	tion and/or in	vestigation, i	n my op	oinion, dea	th occur	red at the time	date and place	, and due	to the cause(s	;)
	To th withir To th comp	Me	29b. Signature and title of certifier				29c.	License	number			29d. Date sign		, Day, Year)	
			Hank	12	ins.	-	· ·	240	137	1		4/25	105		
	10		30. Name and ad was of person who	0							-00~	40 0.5	. ?		
	\		Dr Harry Kap  31. Date filed (Month, Day, Year)	ICIN MS	HOCO Registrar's Signa	CiulD Ci	aurit	SD	SA	LTIN	CASE.	ND 2126	78		
	Sta Registr			2005	egistrar's Signa	& A	whi								
			111 FT W 1 1	1	-										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. illiam G. Winterling State of Maryland / Department of Health and Mental Hygiene 5-2841 KG Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) **Physician** William G. Winterling April 2005 3:15 P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** 33 Berkshire Road Essex Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day Year)

Months Days Hours Min. Feb. 7, 1951 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1⊠M 2□F 54 Yrs. Director 217 54 1596 Maryland Usual Residence of Decedent the Maryland 10a, State 10h Counts 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2√2 No Director Maryland Baltimore Essex 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 33 Berkshire Rd. 21221 236 USA Completed by Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 ☐ Married Specify: White 21215-0036 ō 1 ☐ Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced 'neturel', 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hyglene. other than " Elementary/Secondary (0-12) College (1-4or 5+) Maintenance Apartment Complex 9 other other traumatic event. Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 should be finand Mental H William G. Winterling II Matilda Nies 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Christine C. Hartman (Sister) 328 George Avenue Essex, Md. 21221 Health tem 27 item 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition ō <u>=</u> 1 ☐ Burial 2 IXCremation 3 ☐ Removal from State permit. Page Department of Importent: If any injury or once. 4/26/2005 Bayview Crematory Baltimore, Maryland \* 4 □ Donation 5 □ Other (Specify) 21. Signaure of Funeral Service Licensee 22. Name and Address of Facility Bruzdzinski Funeral Home P.A. MM powere 1407 Old Eastern Avenue Essex, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, effect, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final sunshit wound Priysician enaut resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine sician and burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): physician at the burial Box 68760. Physician/Medical use as 1 attending p IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 Other (specify) P.O. the à signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of cate has l death? certificate 1 Yes 2 No 2 No of Vital Physician: 25. Was case referred to medical director Be 26. Place of Death (Check only one) examiner's Other:  $_{4\,\square\,\text{Nursing Home}}$  5  $\square$  Residence 6  $\square$ Other (Specify) at Scene Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1∑ Yes 2 No this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After Division Hospitel or Attending Injury 1 Natural 5 Pending Subject death. 4-23-05 Found 3=00 M 1 ☐ Yes 2 🗖 No Shot Wimselt investigation 2 Accident Director: 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 X Suicide 4 🗀 Homicio 281. Location (Street and Number or Rural Route Number, City or Town, State) 33 Berkshire Rd Homicide home 24 hours a Medicai 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number MID April 24, 2005 OCME 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar DHMH 17 Rev 1/2001

ORIGINAL

Elem A. Agarle

111 Penn Street

Baltimore, Maryland 21201

m.D

32. Registrar's Signature

CI

LING

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Timle of Death Physician WEBSTER JAMES В. 4:35 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE HOSPICE TOWSON If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1**Ø**M 2□F Days Hours Months Min. 220.20.432 76 Yrs. Director MD Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits itam 27 is marked other then "natural", or Items 23s or 28s-1 show other traumatic evant. The Medical Examinar must be invitibed at NA Director MD BALTIMORE 1 X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3808 RIDGEWOOD AVENUE 21215 USA Completed by Funeral Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. Int: If item 27 is marked other then "natural", or Items 23. 12. Was Decedent Ever in U.S. Armed Forces? 1 MEYes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: BLACK 3 Midowed 4 ☐ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 8/11 GRADE SUPERVISOR SOCIAL SECURITY NA 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) CHARLES WEBSTER CLAIRE REDMOND 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) RENEE CARTER AVE., 3309 SEQUOIA BALTO. MO 21215 20a, Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Department of F Important: If its any injury or of once. cemetery, crematory or other place 1 ଔ Burial 2 ☐ Cremation 3 ☐ Removal from State ARBUTUS 04.30.05 BALTIMORE ⁴ 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeta Service Licensee VAUGHN C. GREENE FUNERAL SERVICE 23a. Part1. Enter to disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 5151 BALTO. NATU PIKE BALTO. MO. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician Lung CANCER munt disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 9 Unknown 9 Unknown ò certificate has been signed irector, page 2 should be del Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? performed? 2□ No 2 NO 1 Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner Other: 4 Nursing Home 5 Residence 6 Nother (Specify) 1 ☐ Yes 2 📆 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Injury 1 Natural 2 Accident 5 Pending death. 1 ☐ Yes 2 ☐ No investigation Diractor 6 Could not be determined 28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To tha Funaral E Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one)

State

Registrar DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

law requires that the death certificate be executed

Hospital or Attanding

Lames

31. Date liled (Month, Day, Year)

29b. Signature and title of certifier

6701 32 Registrar's Signature

Binc

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N. Charle Ct.

29c. License number

1)25205

29d. Date signed (Month, Day, Year)

25 2005

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician Month Year Lorraine M. 9:15 p.<sup>M</sup> Watts April 18 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Moran Manor Nursing Home Westernport Allegany If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) May 14,1927 9. Birthplace (State or Foreign Country) West Virginia **Funeral** 1□M 2**X**F Director 235-32-2118 77 Vrs Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28e-f show treumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 X No Director WV Mineral New Creek 10e. Street and Number 10q. Citizen of What Country? 10f. Zip Code tems 23e P.O. Box 4 Cut-Off Road Completed by Funeral 26743 USA filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 5 1 Yes 2 No Specify 3 X Widowed 4 Divorced "neturel'. White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 8 Seamstress Sewing Factory 17. Father's Name (First, Middle, Last) pormit. Pages 1 and 2 should be file Department of Health and Mental Hy Impordent; If Item 27 Is marked oth any Jury or other treumatic event ottes. 18. Mother's Name (First, Middle, Maiden Surname) Lenard Alger Amanda Franklin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wayne Watts/ Son 26743 P.O. Box 4 New Creek, WV 20b. Place of Disposition (Name of cemetery, crematory or other place) April 23 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State 2005 \* 4 ☐ Donation 5 ☐ Other (Specify) Edge Hill Cemetery Charles Town, WV 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Smith Funeral Home 85 S. Main Street Keyser, WV Man 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Intract all Immediate Cause (Final **Physician** disease or condition resulting in death) months /Medical Due to (or as a consequence of) Examiner Drongy Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed the burial-transit Due to (or as a consequence of): Completed by Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months?
1 Yes 2 XNo Year Month Day 5 ☐ Other (specify) 4□Pregnant at time of death been signed by the a should be detached f P.O. 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 Yes 2 No 3 Probably 4 Nonknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy 2 X No 2 No 1 ☐ Yes 1 ☐ Yes or Attending Physicien: To Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 X No Other: 4 Nursing Home 5 Residence 6 Other (Specify) this filled in by the funeral 28a. Date of Injury (Month, Day Year) 27 Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: After T Natural 5 Pending after death. investigation 1 Yes 2 No 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours To the Funerel 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier lhe! 29d. Date signed (Month, Day, Year) 0 29b. Signature and title of certifier 29c. License number 2005 221244 Oc. 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jesus Tan, M.D. Frostburg Plaza Frostburg, MD 31. Date filed (Month, Day, Year) State Registrar

ORIGINAL

DHMH 17 Rev 1/2001

		•	State of Maryland / Department / Department / Depart		ental Hygien	4000 14511
	Physicia /Medic	al	1. Decedent's Name (First, Middle, Last)  ALVIN	4b. City, Town, or Location of Death	APRIL 21	Year  Year  3. Time of Death  C. County of Death
,	Examin	er	NORTHWEST HOSPITAL CENTER	RANDALLSTOWN		BALTIMORE
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, Yea 04/17/192	
	Director		220-01-3179   1 M M 2 L J F   84 Yrs.   Usual Residence of Decedent		04/17/192	21 MD
	yland Now		10a. State 10b. County 10c. City, Town or Loc	ation		10d. Inside City Limits
	e Mar	ctor	MD BALTIMORE BALTIMORI	Ē		1 □Yes 2√□No
	death with the Maryland ims 23a or 28a-f show riminst ke notified at	Directo	10e. Street and Number WEST	10f. Zip Code	10g. C	Citizen of What Country?
	eath v	Funerai	6 POMONA SOUTH APT. #3  11. Marital Status 12. Was Decedent Ever in U.S. 13. W	21208 Vas Decedent of Hispanic Origin? (Spe	cify Yes or No-	U.S.A. 14. Race - American Indian,
٥	or Items		1 Never Married 2 Married 1 NYes 2 No WW 2	/as Decedent of Hispanic Origin? (Spe Yes, specify Cuban, Mexican, Puerto → Yes 2   No Specify:	Rican, etc.)	Black, White, etc.  Specify: WHITE
5-0036	n 72 hours after death with the Marylan "natural", or Items 23a or 28a-1 show glicul Evarid or must be rediffed at	d by	3 Widowed 4 K∏ Divorced Year or Dates: A KMY			
ה	n 72 h "nati	olete	(Specify only highest grade completed) (Give k	ent's Usual Occupation ind of work done during most of worki O NOT use retired)	ng 16b.	Kind of Business/Industry
717	filed within I Hygiene. other than "rant, II ant,	Completed	Elementary/Secondary (0-12) College (1-4or 5+) RETA	ILER		RETAIL
and	oe filed tal Hygi d other	Be	17. Father's Name (First, Middle, Last)		(First, Middle, Maide	· · · · · · · · · · · · · · · · · · ·
<u>\S</u>	d Men marke	To		DMAN MOLVIN  Address (Street and Number or Rura	I Pauta Numbas Cib	WOHLMUTH
<u>8</u>	s 1 and 2 should Health and Mer Item 27 is marke other treumatic				TIMORE, MD	
ē,	s 1 and of Health item 27 othar tr		20a. Method of Disposition 20b. Place of Dispos			Location - City or Town, State
IImore,	0 0		1 □ Nation 2 □ Cremation 3 □ Memoval from State 14 □ Donation 5 □ Other (Specify) HEBREW FR	IENDSHIP 04/26		TIMORE, MD
Balt	permit. Pag Department Important: I any injury o			Name and Address of Facility SOL		
_	G D E € Ø		23a. Part 1/Enter the disease, or complications that caused the death. Do not enter	OO REISTERSTOWN RO		SVILLE, MD 21208 Approximate
			shock, or heart failure. List only one cause on each in a. Immediate Cause (Final	•	r respiratory arrest,	Interval Between Onset and Death
	Pnysician /Medical		disease or condition resulting in death)  Due to (or as a consequence of):	4114		
	Examiner		Sequentially list conditions.  b. SEPSIS			
	ed sit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury			
	al-trar	Examine	that initiated events resulting in death) Last C. Due to (or as a consequence of):	S MELLITUS		
8/60	certificate be executed ding physician and ise as the burial-transit	licai E	d			
9	leath certifica attending ph	an/Med	IF FEMALE:			
gox	ath or u	lan/	in the past 12 months?	Ectopic pregnancy Other (specify)		23d. Date of delivery  Month Day Year
o.	0 0 0	Physici	1 Yes 2 No 9 Unknown	Other (specify)		
S,	law requires that the de as been signed by the a 2 should be detached t	by P	Part II, Other significant conditions contributing to death but not resulting in the un-	derlying cause given in Part I.	23e. Did tobacco	o use contribute to the cause of death?
ecords,	w require been si should b				1 Tyes	2 No 3 Probably 4 Unknown
Sec.	0 - 0	Completed			24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
Vital R	ician: The certificate hi rector, page	e Col	25. Was case referred to medical	OS Diago of Death	1 Yes 2 1	
	S S ID	To Be	examiner?  1 Yes 2 No Hospital: 1 Jupatient 2 ER/Outpatient	26. Place of Death		6 ☐Other (Specify)
n ot	ding Ph h. After thi funeral		27. Manner of Death 1 SNatural 5 Pending 28a. Dale of Injury (Month, Day Year) 28b. Time of Injury		28d. Describe how in	
SIO	Attending ir death. actor: After by the fune	catio	2 Accident investigation	M 1 Yes 2 No	20f Location /Ctrant	and Number or Rural Route Number,
Division	l or Al after d Dirac J in by	Certification;	4 Homicide determined 28e. Place of Injury - At home, farm, stre building, etc. (Specify)	et, factory, office	City or Town, Sta	ard Number of Aural Abute Number, ite)
	To the Hospital or Attendi within 24 hours after death. To the Funeral Diractor: A completely filled in by the fu		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death			
	To the Hos within 24 h To the Fur completely	ledical	(Check only 2 Medical Examiner: On the basis of examination and/or invone) and manner stated.			
	5 th C 00	75	29b. Signature and title of certifier mehtamo	29c. License number		Date signed (Month, Day, Year)  PM 2157, 20 15 1
	11		30. Name and address of person who completed cause of death (Item 23a) (Type, F			
1	L		1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	D 10 12 5.1		21133
	Sta		31. Date filed (Month, Day, Year) APR 2 7 2005	Coarles		
	Registi	ar	THE WALL TOUR DECEMBER OF			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrer Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death APRIL 25, 2005 Year **Physician** WOLF 9:01 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE N/A 6400-B APOLLO DRIVE If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country GERMANY **Funeral** Months Days Hours Min FEB" 26", 1909 1 □ M 2 🙀 F 524-48-5422 96 Director Usual Residence of Decedent the Maryland 10b. County 10c. City, Town or Location show 10a. State 10d. Inside City Lîmits ir than "natural", or itema 23a or 28a-f shov the Medical Examinar must be notified at 1 Yes 2 No Director N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with USA 21209 6400-B APOLLO DRIVE Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 WHITE 1 ☐ Yes 2 X No Specify: ð 3 ♥ Widowed 4 □ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16h Kind of Business/Industry (Give kind of work done du life. DO NOT use retired) (Specify only highest grade completed) during most of working Elementary/Secondary (0-12) College (1-4or 5+) **HOMEMAKER** OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be WECHSLER **JOSEPH** MALKA UNCBTAINABLE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3220 FALLSTAFF ROAD - BALTIMORE, MD 21215 DAVID WOLF / SON 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) CHEVRA AHAVAS CHESED 04/26/2005 RANDALLSTOWN, MD 21. Signatur of Funeral Service Lice 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caus shock, or heart failure. List only the cause on each ons that caused the death. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine that the death certificate be executed the attending physicien and thed for use as the burial-transit Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 □ Yes 2 ■ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. ģ 1 ☐ Yes 2 ☐ No 3 Probably Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? res 2 No this certificate has 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient Other: 4 Nursing Home 1 Yes 2 No 2 ER/Outpatient 3 DOA 5 sidence 6 Other (Specify) 28d. escribe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of Certification: After 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No death. 2 Accident investigation or Attend after death Diractor: 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital or within 24 hours af To the Funeral D 🔀 certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal 29a. Certifier (Check only one) Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature title of certifier D29606 A Pikesville, Md a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year) 32. Regis

Signature B. Apark

			For State Registrar	State of Mary		Department  Certificate				giene 005	14312
	Physicia /Medic		1. Decedent's Name (First, Middle, Last	nes					2. Date of Dea Month		
	Examin Funeral Director		4a. Fecility Name (If not institution, give  Oniversity of M  5. Social Security Number  222-18-1180	oryland me	n yrs. last bir 72	enter		der 24 Hrs.	8. Date of Birt (Month, Day Jan 2	4c. County of De	-Baltimore, linthplace (State or Foreign Country)
	D	tor	Usuel Residence of Decedent   10a. State   10b. County   DE   Sussex	10		n or Location Laur	e1		Jan. 2	.5,1955	irginia 10d. Inside City Limits 1⊠Yes 2□No
	with the 3e or 28a	I Director	10e. Street and Number 721 West 6th S	treet		10f. Zip	Code 19956	<u>,                                      </u>		10g. Citizen of What	
980	be filed within 72 hours after death with the Maryland stal Hygiene.  d other then "naturel", or items 23e or 28e-f show event, the Madical Examiner must be notified at	by Funeral	11. Marital Status  1  Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Eve Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:	r in U.S.	13. Was Deced If Yes, spec			ecify Yes or No- Rican, etc.)	14. Race - Ai Black, W Specify:	nerican Indian, nite, etc. Black
Maryland 21215-0036	within 72 hou lene. 'then "nature the Modical E	Completed	15. Decedent's Edi (Specify only highest grad			Decedent's Usua (Give kind of wor life. DO NOT us Laborer	k done during i	nost of work	ing	16b. Kind of Busines	·
yland 2	should be filed and Mental Hygie and Mental Hygie is marked other sumatic event, it	To Be Co	17. Father's Name (First, Middle, Last) Herman Goodman				Pε	earl V	Virgin	Maiden Sumame) ia Harma	
	Health tem 27 ther tr		19a. Informant's Name/Relationship (T)  Mozett Stance1  20a. Method of Disposition	1/Daughte	er 16		wood F	Rd., 1		or, City or Town, State  3, Wilmi  20c. Location - City	
Baltimore,	permit. Pages Department of Importent: If it any injury or o		1 ▼ Burial 2 □ Cremation 3 □ I  '4 □ Donation 5 □ Other (Specify,  21. Signature of Funeral Service Licens	Aemovar nom State		tthews Ch. 22. Name an	Cenetery d Address of Fa	acility Fra	amptom		Delaware Home, P.A.
	Physician /Medical Examiner		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of limmediate Cause (Final disease or condition resulting in death)	ilications that caused the ne cause on each line.  a. Due to (or as a co	- B	not enter the mode					Approximate Interval Between Onset and Death S Months
8760,	ate be executed hysicien and the burial-transit	licai Examiner	Sequentially list conditions, ir any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c.  Due to (or as a co							
.O. Box 6	The law requires that the death certificate be executed ate has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of p 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at tim 9 ☐ Unknown	☐ Fetal death	3 □Ectopic pr 5 □ Other (sp				23d. Date of Month	delivery Day Year
ecords, P	w requires that been signed t should be det	by	Part II. Other significant conditions of	ntributing to death but n	not resulting i	n the underlying ca	ause given in P	art I.	23e. Did to		to the cause of death?  Probably 4 Unknown
I Reco	: The law requirate has been page 2 should	Completed	End-stage reno Diabetes Mellit						24a. Was autor perio 1 Yes	an 24b. Were prior med? death 2 No 1 Y	
Division of Vita	Attending Physicien: Th r death. ector: After this certificate by the funeral director, pag	tion: To Be	25. Was case referred to medical examiner?  1 Yes 2 No  27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	Hospital: 1 The patient 28a. Date of Injury (Month, Day Y	2 ER/Ou 28b.		Othor	Nursing Ho		nne) dence 6 □Other (S now injury occurred	pecify)
Divisi	a H H	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc. (		arm, street, factory	r, office		28f. Location (8 City or Tov	Street and Number or vn, State)	Rural Route Number,
	To the Hospitel within 24 hours a To the Funerel Completely filled	edicai		rsician: To the best of n iner: On the basis of ex and manner stated	camination ar						
	To I To I	Σ	29b. Signature and title of certifier	n mo		290	License numb			April 10	
			30 Name and address of person who co	22 South	Groom	2 SHOOLY	, Suite	NE3E	110 , Ba	Himore, n	1061K CM
	Sta Regist		31. Date filed (Month, Day, Year) APR 1 2 2005	32. Registrar's	Signature	Jack!					

Amended Item	#5	Please Type or Pa Per F. Home, 04/21/State of Page 1	rint in Black In	delible lnk.	. Ensure A	All Copies	Are Legible	
Amended ite		l- State #20b,4/14/05, per	/F. Home, Ce	rtificate of	Death E.T	, WCHD	Reg. No.	4313
Physic		Decedent's Name (First, Middle, Last)  William Edward Be	ohager			2. Date of De Month	Day Ye	6.4
/Med Exami		4a. Facility Name (If not institution, give street and number		4b. Cîty, Town, o	or Location of Death		13, 2005 4c. County of D	5:40P M
		II429 Gum Point Rd.  5. Social Security Number 6. Sex 7.	Age (In yrs. last birthday)	Berli If Under 1 Year		O Data of Bi	Worcest	
Funeral Director		212-40-6999 15M 2DF	Yrs.	Months Days	Hours Min.	(Month, Da	iy, Year)	Birthplace (State or Foreign Country) MD
iand		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or Lo	ocation				10d. Inside City Limits
a-feh	ctor	MD Worcester	Berlin					1 ☐ Yes 2 No
with the	Director	10e. Street and Number		10f. Zip Code			10g. Citizen of What	Country?
death ma 23	Funeral	II429 Gum Point Rd.  11. Marital Status 12. Was Decede	nt Ever in U.S. 13.	21811 Was Decedent of H	Hispanic Origin? (Si an, Mexican, Puert	pecify Yes or No	US - 14. Race - A	merican Indian,
36 s after ; or Ita	by Fui	Armed Force  1 □ Never Married 2 Married 1 Never Married 2 Married 1 Never 2 If Yes, Give  3 □ Widowed 4 □ Divorced Year or Date	□N9 C	1 ☐ Yes 2 ☑ No		o Hican, etc.)		/hite, etc. White
5-00		15. Decedent's Education	16a. Dece	dent's Usual Occup	pation		16b. Kind of Busine	
1218 vithln 7 ne. han 'n	Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4c)	life.	DO NOT use retired	during most of wor d)	King		
id 2. filled v Hygie other t	Be Co	17. Father's Name (First, Middle, Last)		Sales	18. Mother's Nam	ne (First, Middle	Automok , Maiden Sumame)	oile
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, it a Modical Exemination to notified at once.	To B	Edward Bohager			Alma (	Greenst	reet	
Mar d 2 sh th and th and traum		19a. Informant's Name/Relationship (Type, Print)  Constance Bohager (wife					er, City or Town, State Md. 21811	e, Zip Code)
othar	-	20a. Method of Disposition	20b. Place of Dispo			Date	20c. Location - City	or Town, State
Baltimore, sermit. Pages 1 a. Department of Hee amportant; if them amportant; if them amportant; if them amportant; if them amportant; if them amportant; if them amportant; if them amportant; if them amportant; if them amportant; if them amportant; if them amportant; if them amportant; if them amportant; if them amportant; if them amportant; if them amportant; if the amportant is a second amportant; if the amportant is a second amportant; if the amportant is a second amportant is a second amportant in the amportant is a second amportant in the amportant is a second amportant in the amportant is a second amportant in the amportant is a second amportant in the amportant in the amportant is a second amportant in the amportant in t		1 ☐ Burial 2 X Cremation 3 ☐ Removal from Sta `4 ☐ Donation 5 ☐ Other (Specify)	Cape Hei	nlopen Ci	rem. 4/18	<del>-0</del> 5~	Frankford	i,DE
Ball permit Depar Impor any In		21. Signature of Funeral Service Licensee					age Funer	al Home
113		23 . Part1. Enter the c sease, or completions that have shock, or heart filtere. List only one cause by each			St., Bei			Approximate Interval Between
Physician		Immediate Cause (Final disease or condition resulting in death)	1 4 4 4	winema	A			Onget and Death
/Medical Examiner		Due to (or	as a consequence of):					1001
# G	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury	as a consequence of):					
D, executed an and rial-transit	Examiner	that initiated events c.	as a consequence of):					
	ledical E	d						
Box 6876; eath certificate be attending physici for use as the bu	/Med	IF FEMALE: 230 If you cutton	no of prognancy				0	
Box death cert	Physician/M		2 Fetal death 3	☐Ectopic pregnancy ☐ Other (specify)	у		23d. Date of Month	delivery Day Year
P.O. that the debut by the detached	Phys	9 ☐ Unknown 9☐ Unknown						
ds, uires th signec	by	Part II. Other significant conditions contributing to death	n but not resulting in the u	inderlying cause giv	ven in Part I.			e to the cause of death?  Probably 4 Dunknown
Vital Records, sician: The law requires to certificate has been signer irector, page 2 should be considered.	ompleted					24a. Was		autopsy findings available
II Rec	Com					autor perfo	rmed? death	to completion of cause of i? ′es 2□ No
f Vital Roysician: The is certificate h	o Be	25. Was case referred to medical examiner?  1  Yes 2 No Hospital: 1 Inper	ations 2 DER/Outpation	- act pos Oth	26. Place of Dear	1		
Division of to attending Physical after death. Director: After this if in by the funeral of in by the funeral of	<b> -</b>	27. Manny of Death 28a. Date of I		IL 3 DOA	y at	-	dence 6 □Other (S how injury occurred	ipecify)
Sion Sion Seath. Tor: Af the fur	catic	2 Accident investigation		M 1 🗆	Yes 2 No	006 1		2 12 11
Division and an arrange of the control of the contr	Certification;	determined 200. Flace of	Injury - At home, farm, st etc. (Specify)	reet, factory, office		City or Tox	Street and Number or vn, State)	Rural Route Number,
Division of Vital Records, P.O. Box 68766  To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours aftar death.  To the Funeral Director: After this certificate hes been signed by the attending physicic completely filled in by the funeral director, page 2 should be detached for use as the bu	edical C	29a. Certifier 1 Certifying Physician: To the be 2 Medical Examiner: On the basis	s of examination and/or in	h occurred at the tin	me, date and place,	, and due to the rred at the time.	cause(s) and manner date and place, and c	as stated, due to the cause(s)
To the vithin 2 or the omplet	Med	one) and manner  29b. Signature and title of certifier	stated.	29c. Licens			29d. Date signed (Mo	``
- se o		Kier Green	MO	_   1)-	35 76d	4	4/1	4/05
G F4	1	30. Name and see sets of person who completed sause.	death (Item 23a) (Type,	Print)	ity, md	21842	11	
Si	ate	31. Date filed (Month, Day, Year) 4 2005	strar's Signature	e	my ind	21076		
Regis	trar	APR 1 # 2005	se A A	1				

			1 - For State Registrar	State o	of Maryland /		rtment of He tificate of D		•	giene Reg. No.	105	143	
	lill w	49	Decedent's Name (First, Middle, I	Last)					2. Date of De		Year	3. Time of	Death
	Physicia /Medic		James Le	vin Bak	er				April		2005	4:15	A M
5	Examin		4a. Facility Name (If not institution, g				4b. City, Town, or I	Location of D			ounty of Death		
			Caroline Nurs:	ing Hom	ne, Inc.		Dentor			Car	roline		
	Funeral		Social Security Number 6	Sex 1120 M 2 ☐ F	7. Age (In yrs. last i		If Under 1 Year Months Days	Hours N	Hrs. 8. Date of Bir Min. (Month, Da	th y, Year)	9. Birthp Coun	lece (State or try)	r Forei <b>g</b> n
	Director		717-07-9657	DEUM ZUF	89	Yrs.			April 1	6, 19	15 Mar	yland	
	and w		Usual Residence of Decedent  10a, State 10b. County		10c. City, To	wn or Lo	cation				1	0d. Inside Cit	y Limits
	sho	ក	,									1 <b>y</b> Yes	2 🗌 No
	the M	Directo	Maryland Caroli  10e. Street and Number	ine	Der	nton	10f. Zip Code			10n Citize	n of What Cour	ntry?	
	with a or										d State	•	
	be filed within 72 hours after death with the Maryland all Hygiene.  del Hygiene.  dether than "natural", or items 23a or 28a-f show event, the Medical Exeminer must be notified at event.	Funeral	509 Franklin Stre		cedent Ever in U.S.	13.1	21629 Was Decedent of His	panic Origin'	? (Specify Yes or No	- 14	. Race - Americ	Amer	ica -
_	ter d	Š	1 ☐ Never Married 2 🔀 Married	Armed F	orces?	1	f Yes, specify Cuban	, Mexican, P	uerto Rican, etc.)		Black, White,		
5	hours after tural', or ite al Exemine	by F	3 ☐ Widowed 4 ☐ Divorced	If Yes, G Year or I	<sup>2</sup> □No 1942- ive Dates: 1946		I∐Yes 2 🙀 No	Specify:		S	pecify: Cauca	sian	
21215-0036	2 hou		15. Decedent's		16	Sa. Deced	lent's Usual Occupat	tion		16b. Kind	of Business/Inc		
5 5	n n n n	ple	(Specify only highest ( Elementary/Secondary (0-12)		) (1-4or 5+)	(Give life. l	kind of work done du DO NOT use retired)	uring most of	working				
77	filed within 72 Hygiene. other than "na! ent, the Wedic	Completed	11 HS Grad	College	(1-401 54)		Carpenter			Rail	road		
ğ	othe	BeC	17. Father's Name (First, Middle, La	ist)					Name (First, Middle,	Maiden Su	ımame)		
<u>a</u>	thould be ad Mental marked o matic eve	ToB	Beniah Le	ewis Bak	er			Hanna	a Esther P	∞le			
Maryland	R B E E	_	19a. Informant's Name/Relationship	p (Type, Print)	1	9b. Mailir	g Address (Street ar	n <b>d Number</b> o	r Rural Route Numbe	er, City or T	own, State, Zip	Code)	
_	127 E 3		Ruth N. Baker	Wife	e 5	509 F	ranklin S	treet,	Denton,	Maryl	and 216	29	
Baltimore,	一王るち		20a. Method of Disposition		20b. Place	of Dieno	sition (Name of natory or other place		Date	20c. Loca	tion - City or To	wn, State	
Ë			1 Donation 5 Other (Spe		Julia		Cemetery		3/2005	near Dent	on, Mar	vland	
Ħ	permit. Pag Department Importent: I any injury o		21. Signature of Funeral Service Li	conses 2		22	. Name and Address	s of Facility				,	
ñ	Per in g		+ Lauxopy	- 1 /loc	~	1	loore Fune	ral Ho	me, P.A. Street, D	onton	Marvil	21 Pure	620
			23a. Part1. Enter the disease, or co	omplications that	caused the death. D	o not ent	er the mode of dying	, such as car	rdiac or respiratory a	rrest,	Y LICIL Y	Approximate Interval Bety	9
8	All Control		shock, or heart failure. List or Immediate Cause (Final	ny one cause on	each line.	a	-				,	Onset and D	
3	Pnysician /Medical		disease or condition resulting in death)	a. Die to	o (or as a consequence	ce of):	a					oech	-
*	Examiner	1		R	1000	201	Cal	KPS					
P		ē	Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that interest and executed executed the conditions of the conditio	b. Due 1	Or as a consequence	e uth	CCC						
	be executed sician and burial-transit	Examiner	Cause. Enter Underlying Cause (Disease or injury that initiated events										
Č.	exec in an	Exa	resulting in death) Last	Due to	(or as a consequence	ce of):							
8760,	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	dical		d									
68	ificate g phys as the	ed		_						- 1			
ŏ	leath certific attending p	Physician/Me	IF FEMALE: 23b. Was decedent pregnant		utcome of pregnancy		Totalia assault			230	d. Date of delive	Эгу	
Ď	death e atte d for	Cla	in the past 12 months? 1 ☐ Yes 2 ☐ No	4□Preg	birth 2 Fetal dea mant at time of death		Ectopic pregnancy Other (specify)				Month	Day Y	/ear
0	that the de led by the a detached f	hys	9 Unknown	9□ Unk	nown								
ر. ص	res tha igned I be det	by P	Part II. Other significant condition	s contributing to	death but not resulting	g in the u	nderlying cause give	n in Part I.	23e. Did t	obacco use	contribute to the	ne cause of d	eath?
ĕ	w require been sig should b	Pa	COLONAL	y ar	Lery	D1	SCAS	<u>e</u>	10	Yes 2 🚅	No 3 ☐ Prob	ably 4 🗆 U	Inknown
Records,	s bee	Set		/	/				24a. Was		24b. Were auto	psy findings a	available
	he lav e has age 2	Completed				-				rmed?	prior to col death? 1 \( \sum \text{Yes}	mpletion of ca	luse of
Vital	inficat	O O	25. Was case referred to medical					26. Place of	1 ☐ Yes Death (Check only of	2. No	1 1 103	20110	
>	Attending Physician: or death. ector: After this certific: by the funeral director.	0 8	examiner? 1 ☐ Yes 2 ☐ No	Hospital:	Inpatient 2 ER/	Outpatien	t 3□ DOA Other	-	ng Home 5 ☐ Resi		Other (Specif	v)	
Division of	a Physical of eral of	i.	27. Manner of Death	28a. Date	of Injury 28t	. Time of			28d. Describe			,,	
<u>o</u>	th.: Th.: After e fun	t e	1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investiga		nth, Day Year)	Injury		: ′es 2⊡No					
VIS.	Attending death.	ifici	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	250. Plac	e of Injury - At home,	, farm, str	eet, factory, office	- 1100	28f. Location (		Number or Rura	I Route Num	ber.
ā	el or A s after il Direction by	Certification:	4 D Homicide	Dulle	ding, etc. (Specify)				Chy of 10	WII, DIALO			
	spit hours inere		29a. Certifier Certifying	Physician: To th	ne best of my knowled	dge, death	occurred at the time	e, date and p	lace, and due to the	cause(s) ar	nd manner as s	tated.	
	ne Hd	Medical	(Check only 2 Medical Ex	xeminer: On the and ma	basis of examination nner stated.	and/or in	vestigation, in my opi	inion, death o	occurred at the time,	date and pl	lace, and due to	the cause(s)	1
	To the Hospitel or Attending Physician: The I within 24 hours after death.  To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Ĭ	29b. Signature and title of certifier	0	0	. 5	29c. License	number		29d. Date s	signed (Month,	Day, Year)	
}			James	-134	Ler 1	D	D3	137	6	4-11-	05		
			30. Name and address of person w	no completed car	use of death (Item 23	a) (Type,	Print)		7	1	. ,		
			James SI	Res	920	Me	entot	Se	Dei	Tar	1 178	2	
	Sta	ate	31. Date filed (Month, Day, Year)	32.	Registrar's Signature								
	Regist	rar	APR 1 1	2005	Dagree &	2 6	mark t						

			For Stete Registrer	Stat	te of Ma	arylar	-			lealth a Death		lental Hy	giene	005		1431	5
	Physici	an.	1. Decedent's Name (First, Middle		0110							2. Date of De	Day	Ye	ar_	3. Time of Dea	
	/Medic	al	4a. Facility Name (If not institution		ello			4h Cih	Taura	r Location o	( D - 1)	APri	_			2:00 T	М
	Examin	er	University of V			ical	Systems			non			NI	County of D	eatn		
	Funeral		5. Social Security Number	6. Sex		e (In yrs.	last birthday)	If Unde Months	r 1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da	th	9.	Birthpl Count	ace (State or Fo	reign
	Director		215 50 3406	1∭ M 2□	5	4	Yrs.	WOTHERS	Days	Hours	IVIIII.	May 2,	1950	0		yland	
	land		Usual Residence of Decedent  10a. State 10b. County			10c. Ci	ty, Town or Lo	cation							10	d. Inside City Li	mits
	be filed within 72 hours after death with the Maryland all bygiene. Ide Hygiene. Ide ther then "neturel", or items 23e or 28e-f show event. Its Modical Examinant te redified at	ţō	MD Balt	imore		Wo	odstoc	k								1 ☐ Yes 2 <b>X</b>	] No
	n the	lec Lec	10e. Street and Number			7.0		-	p Code				10g. Citi	zen of What	Count	ry?	
	23e c	Funeral Director	1 Offutt Court					2	21163				Ur	nited	Sta	ites	
	tems	nuel	11. Marital Status	Arm	Decedent led Forces?		J.S. 13.	Was Dece f Yes, spe	dent of Hi cify Cuba	ispanic Ori in, Mexicar	gin? (Spen, Puerto	ecity Yes or No Rican, etc.)	)-	14. Race - A Black, W			
36	rs afte	by F	1 Never Married 2 XMarr 3 Widowed 4 Divorced	If Ye	Yes 2 <b>X</b> es, Give r or Dates:	10		1 □ Yes	2 <b>X</b> No	Specify:				Specify:	r.71-		
21215-0036	2 hou	ted t	15. Deceden	t's Education			16a. Dece						16b. Kii	nd of Busine		ite ustrv	
215	hin 72 n "ne Medi	plet	(Specify only highe Elementary/Secondary (0-12)		eted) ege (1-4or 5	(±)	(Give	kind of wo	ork done d ise retired	during mos I)	t of worki	ing				,	
21		Completed		2			Own	er					Н	ome Bu	ilo	er	
pu	should be filed and Mental Hygi marked other matic event,	Be	17. Father's Name (First, Middle,									(First, Middle		Sumame)			
Уa	should be and Mental s marked o umatic eve	은	James F. Coste									'Farra					
Maryland	2 8 8		19a. Informant's Name/Relations				1					Il Route Numb			e, Zip	Code)	
	of Health item 27 other tr		Barbara P. Cos  20a. Method of Disposition	сетто/и	ille	20b. I	Place of Dispo	sition (Na	me of	1		ck, MD		cation - City	or Toy	m. State	
Baltimore,	Pages nent of int: ff it iry or o		1 Burial 2 ☐ Cremation  4 ☐ Donation 5 ☐ Other (S	_	from State		cemetery, crer Alpho	natory or o	other plac		_16_	2005					
Ħ			21. Signature of Funeral Service		0.4	M01								istock		ly FH I:	nc
ä	permit. Departr Importe eny inju		Dem Col	D= -1	will											MD 2104	
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications only one cause	that caused	the dear	th. Do not ent	er the mod	de of dyin	g, such as	cardiac o	or respiratory a	rrest,			Approximate Interval Between	1
	Physician "	Ü	Immediate Cause (Final disease or condition		etast		L ESO	pna	geal	Co	unce	er e				Onset and Deati	
	/Medical Examiner		resulting in death)	Di Di	ue to (or as	a consec	quence of):		1								
в	Examine	lus.	Sequentially list conditions,	b	- 1- /-												
	be asit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		ue to (or as	a consec	quence of):										
	The law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the burial transit	Examiner	that initiated events resulting in death) Last	c	ue to (or as	a consec	quence of);								-		
8760	e be e	dlcal E		L <sub>d</sub>													
89	tificate I g physi as the b	led															
XO	eath certific attending p	Physician/Me	IF FEMALE: 23b. Was decedent pregnant		s, outcome Live birth			Ectopic p	regnancy				2	3d. Date of		•	
). B	it the dea by the att tached fo	slcl	in the past 12 months?  1  Yes 2 No	4	Pregnant at Unknown			Other (st						Month	l	Day Year	
P.0	that the	Phy	9 ☐ Unknown  Part II. Other significant condition	one contribution	a to doath h	ut oot roo	sulting in the	adorbias a		on in Dant I		22a Did	abaaaa	on contribute	a to the	cause of death	2
ds,	signe d be c	l by	Tatti. Otto significant conditi	Sits Contributing	g to death b	at not res	sulting in the di	identyling t	ause give	en in Fail i			Yes 2		Proba	1	
Records,	w require been si should b	Completed														-	
Rec	The tay ate has page 2	m d										24a. Was auto perfo	psy ormed?	prior death	to com	sy findings avail- pletion of cause	of
		e Cc	25. Was case referred to medica							on Disease	of Dooth	1 Tes	2 X No	1 D Y	es 2	!□ No	
>	Physicien: this certific ral director,	O B	examiner? 1 ☐ Yes 2 🛣 No	Hospital:	1 Inpatie	nt 2	ER/Outpatien	t 3 D	Othe	3.07		n <i>(Check only o</i> me 5 ☐ Resi		□Other (S	nacifu		
		n; T	27. Manner of Death		Date of Injur	ry	28b. Time of Injury		28c. Injury Work	at		28d. Describe			podity /		
ioi	Attending ir death. ector: After by the fune	atlo	1 Natural 5 Pendir 2 Accident investi	gation	(, 02)			М		Yes 2 □ I	No						
Division	or Att	Certification;	3 Suicide 6 Could 4 Homicide determ	ined 286.	Place of Injubuilding, etc	ury - At h	ome, farm, str	eet, factor	y, office		1	28f. Location ( City or To	Street and wn, State)	d Number or	Rurai	Route Number,	
Ω	spital o		Note that the same of the same														
	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medical	29a. Certifier f Certifyir (Check only 2 Medical one)	ig Physician: T Examiner: On	To the best of the basis of I manner sta	examina	owledge, death ation and/or in	occurred estigation	at the tim i, in my op	ie, date an pinion, dea	d place, a th occum	and due to the ed at the time,	cause(s) date and	and manner place, and o	as sta lue to	ted. he cause(s)	
	To the Hos within 24 h To the Fur completely	Med	29b. Signature and title of certifie		1 1110111111111111111111111111111111111			29	c. License	number			29d. Date	signed (Ma	onth, D	ay, Year)	
	<b>⊢ ≶ ⊢</b> ŏ	1 3		Kare	mil	ND			PIT	708				11 12			
			30 Name and address of person	who completed	d cause of d	eath (Iter	m 23a) (Type,	Drint)							,		
٥٠٠ (			Heidi Karon M	D, 22	S. Gr	een	e ar	eet.	150	Ltin	rore	. Mar	yla	na L	14		
	Sta		31. Date filed (Month, Day, Year)	2005	32 Negistra	ar's Signa	ature	- M									

DHMH 17 Rev 1/2001

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		4	For State Registrar	State of Maryla	•	artment of He tificate of E			iene og. No.	
	Physicia	20	1. Decedent's Name (First, Middle, La	•			2	2. Date of Death		3. Time of Delathy
	/Medic		RUDOLPH D.	COULBOURNI	Ľ.			pril_	6 2005	5:59 A <sup>M</sup>
	Examin	er	4a. Facility Name (If not institution, giv 3186 Choptank			4b. City, Town, or Pres			4c. County of Deat	
	Funeral		5. Social Security Number 6. S		rs. last birthday)	If Under 1 Year		B. Date of Birth (Month, Day,		
	Director		215-36-2260 19 Usual Residence of Decedent	<b>™</b> 2□ F	89 Yrs.	Months Days		pr. 30		hplace (State or Foreign untry) ryland
	land ow		10a. State 10b. County	10c.	City, Town or Lo	cation				10d. Inside City Limits
	ter death with the Marylan Items 23a or 28a-f show Lief must be multified at	ctor	MD Caro	line		Prest	on			1 ☐ Yes 2∜ ☐ No
	vith th	Dire	10e. Street and Number			10f. Zip Code			og. Citizen of What Co	•
	eath v	erai	3186 Choptank	Koad  12. Was Decedent Ever in	11.5		655		Jnited St	
36	72 hours after death with the Maryland natural, or Items 23s or 28s-1 show idical Examinational be notified at	by Funeral Director	11. Marital Status  1 □ Never Married 2 ☑ Married  3 □ Widowed 4 □ Divorced	Armed Forces?  1 Yes 2 No If Yes, Give Year or Dates:		f Yes, specify Cubar	spanic Origin? (Speci n, Mexican, Puerto Ri Specify:	ican, etc.)	Black, White	
ò	2 hou		15. Decedent's E	ducation	16a. Deced	dent's Usual Occupa	tion		16b. Kind of Business/	Industry
215	within 72 ho ene. than "natur	Completed	(Specify only highest gra Elementary/Secondary (0-12)	College (1-4or 5+)	life. I		uring most of working	P A	Agricultu	re/Dairy/
21	70 00 5		17. Father's Name (First, Middle, Last			Farme			Pou1t	ry
Maryland 21215-0036	2 to 2 to 2	Be c	Darcy Wright C				18. Mother's Name ( Ethel		,	
Z	d 2 should b th and Ments 7 is marked traumatic e	은	19a. Informant's Name/Relationship		19b. Mailir	ng Address (Street a			City or Town, State, 2	Zin Code)
	01 00 00		Mildred Coulbo	**		-	nk Rd. P			655
ore,	oth oth		20a. Method of Disposition	20	b. Place of Dispo	sition (Name of matory or other place	Da Da	te 2	20c. Location - City or	Town, State
ij	nit. Pages artment of l ortant; If it injury or o		1 XBurial 2 ☐ Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Special	Tuelling all lingli State	r. Orde	er Cemet	ery 4/9/		Preston,	•
Baltimore,	permit. Page Department of Important; If any injury or once.		21. Signature of Funeral Service Licer	m. Coale					Funeral leralsbur	Home, PA g,MD 21632
п			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the done cause on each line.	eath. Do not ent	er the mode of dying	, such as cardiac or	respiratory arre	est,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)	a. Coro	nary	arte	sy de	seas	e	Onset and Death  S  S  S  S  S  S  S  S  S  S  S  S  S
	/Medical Examiner		Tooling in douin,	Due to (or as a con-	sequence of):		,			O
	7 =	ner	Sequentially list conditions, if any, leading to initiodiate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to (or as a corr	sequence oi):					
	ecuter and -trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	C.						
60,	tificate be executed ig physician and as the burial-transit			Due to (or as a con-	sequence or):					
68760,	uficate g phys as the	edicai		d						
.O. Box	The law requires that the death certi ate has been signed by the attending page 2 should be detached for use a	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pre 1 Live birth 2 F 4 Pregnant at time of 9 Unknown	etal death 3	Ectopic pregnancy Other (specify)			23d. Date of del Month	ive <i>r</i> y Day Year
<u>α</u>	s that ned b	by Ph	Part II. Other significant conditions	contributing to death but not	resulting in the u	nderlying cause give	n in Part I.	23e. Did tob	pacco use contribute to	the cause of death?
rds	w requires been sign should be		hyperten	sien	-			1 ☐ Ye	s 2□No 3□Pr	obably 4 Onknown
Records,	e law re has beo	Completed	atrial,	Coullate	on			24a. Was ar		topsy findings available completion of cause of
= B		Corr	Congestra	e heart	facto	re		perform	ned? death? 202 No 1 ☐ Yes	
Vital	Physicien: Th this certificate ral director, pag	Be	25. Was case referred o medical examiner?	Hospital:	0	Otho	26. Place of Death (	Check only one	9)	
of	Phys r this ral dii	. To	1 Yes 2 No 27. Manne of Death	1 ☐ Inpatient 2	2 ER/Outpatier 28b. Time of		4   Nursing nome		nce 6 Other (Special of the following occurred)	cify)
lon	Attending F r death. ector: After by the funer	tion	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year		Work	? ′es 2 □ No		W III ary Social Ca	
Division	or in	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - A building, etc. (Sp	At home, farm, str ecify)	eet, factory, office	28	f. Location (Str City or Town	reet and Number or Ru , State)	ıral Route Number,
	To the Hospitel or Attenwithin 24 hours after deall To the Funeral Director: completely filled in by the	Medical Ce	29a. Certifier 1 Certifying Pl	nysician: To the best of my miner: On the basis of exam and manner stated.	knowledge, death	h occurred at the tim vestigation, in my op	e, date and place, an inion, death occurred	nd due to the ca	use(s) and manner as ate and place, and due	stated. to the cause(s)
	Fo the within Fo the	Me	29b. Signature and title of certifier	C STITULING STATEGO.		29c. License	number	29	d. Date signed (Monti	h. Day, Year)
)	,- ,- ,		Auch	fradi,	20.	H4	7357		4-7-0	5
			30 Name and address of person who	completed cause of death (	Item 23a) (Type,	Print)	ID:	C -	4-7-0 2204 Ea	1
			31. Date filed (Month, Day, Year)	32. Registrar's Si	O.	5221 18	al prive	sul	2 404 Ea	aston, MD
	Sta Registi		APR - 7 200	The second secon	H Aga	A)				

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 2005 APRIL 10 ROBERTA C. CLINKSCALE 4:27 A M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner PRINCE GEORGE'S HOSPITAL PRINCE GEORGE'S CHEVERLY | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Min. | (Month, Day, Year) | MAY 30 10 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🕱 F Director 579-74-0233 Yrs. 1934 SOUTH CAROLINA 70 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show in than "natural", or itema 23a or 28a-f show the Medical Examiner must be notified at 1 X Yes 2 □ No MDPRINCE GEORGE'S CAPITOL HEIGHTS Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 500 QUARRY AVENUE 20743 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married Baitimore, Maryland 21215-0036 1 ☐ Yes 2X No þ Specify: BLACK 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done di life. DO NOT use retired) during most of working Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) 4 YRS REGISTERED NURSE GOVERNMENT 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any injury or other traumatic event once. 18. Mother's Name (First, Middle, Maiden Sumame) Be EDWARD ROBINSON FLOSSIE BROWN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ROBIN FELDER/DAUGHTER 7209 CHECKERBERRY WAY UPPER MARLBORO, MARYLAND 20772 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place) 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) RIVERDALE CREMATORY 4/16/05 RIVERDALE, MARYLAND 21. Signature of Funeral Service Licensee 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 7474 LANDOVER RD. LANDOVER, MAKYLAND 20785 23a. Part1. Enter the dise vie, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Fin V INTRACRANIAL **Physician** HEMORRHAGE disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** YPERTENSION Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of). Examiner The law requires that the death certificate be executed burial-transit and resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, signed by the attending physicien d be detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Day Month Year 4☐ Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown peeu 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an this certificate has page 2 autopsy performed? 2 0 No 1 Yes Attending Physician: director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🗙 No 1 Inpatient Certification: To 2 KER/Outpatient 3 DOA completely filled in by the funeral 28b. Time of 27 Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Director: After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 4 Homicide 5 within 24 hours To the Funeral 1 🖔 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 4-13-25 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GEORGE 3001 DONALD 32. Registrar's Signature 31. Date filed (Month, Day, Year) State APR 1 4 2005 Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death Decedent's Name (First, Middle, Last) 3. Time of Death Month April **Physician** 20 ay 2005 DEAN CURTIS 6:50 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Alice Byrd Tawes Nursing Home Crisfield Somerset If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
September 6, 1947 If Under 1 Year 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days XXM 2□ F Yrs. Director 218-54-5129 57 Maryland Usual Residence of Decedent 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits ral', or items 23e or 28e-f ehow Examiner must be notified at 1X Yes 2 □ No Director Crisfield Somerset Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21817 94 Somers Cove Apartments USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify: ģ 3 ☐ Widowed 4 ☐ Divorced White 'netural', r than "neture the Medical I Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Painter Painting other 7 Is marked othe traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Maxwell Eugene Curtis Marion Lorraine Abbott ۵ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health tem 27 l 3 Standard Avenue - Crisfield, Maryland 21817
Disposition (Name of Date 20c. Location - City or Town, State Doug Curtis (Brother) item 2 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition important: if it eny injury or o once. 1 DBurial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) S lamons United Methodist Cemetery 4/23/05 Solomons, Maryland 21. Signature of Funeral Service License 22. Name and Address of Facility Bradshaw & Sons Funeral Home Robert H. Bradshaw, Jr. 306 W. Main Street - Crisfie 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 306 W. Main Street - Crisfield, MD 21817 **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical LUNG CANCER ETASTATIC Examiner Due to (or as a consequence of) Physiclan/Medical Examiner physician and s the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Due to (or as a consequence of) attending pl 23b. Did tobecco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 1XYes 2□ No 3 Probably 4 Unknown Completed by 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? s certificate has be director, page 2 s 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 No Other: Washing Home 5 Residence 6 Other (Specify) မှ 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Director: After thi I in by the funeral 27. Mapner of Death 1/2 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pendina 1 □ Yes 2 □ No 2 ☐ Accident investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 🗆 Homicide within 24 hours of To the Funerel Completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie Medical (Check only 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2005 48098 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Λ

Vijay Karumbunathan, M.D.201 Hall HIghway, Crisfield, MD 21817

10000

32. Segistrar's Signature

2005

Registrar

State

31. Date filed (Month, Day, Year)

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health end Mental Hygiene.

**Department** 

or Attending Physicien: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760.

Saltimore, Maryland 21215-0020

		•	1 - For State Registrar				nd / Dep.		t of H	ealth a	and M	•		ริกเ	95	14319
			1. Decedent's Name (First, Mid	dle, Last)								2. Date of D	eath			3. Time of Death
	Physicia /Medic		Jean Mari	e Dei	gnan							Month O4	15	ay O	OS	0552 M
	Examin		4a. Facility Name (If not institut	on, give s	reet and numb	ber)		4b. City,	Town, or	Location	of Death		4	c. Count	y of Death	
				gione	W Ned	ical (	enter		Sal	isbu	14	_		WI	CONI	0
	uneral		5. Social Security Number 158–20–2846	6. Sex	M 2 F 7	. Age (In yr: 77	s. last birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	Min.	8. Date of E (Month, L	Day, Yea		9. Birthp	lace (State or Foreign try)
D	irector		Usual Residence of Decedent				113.					3-5-19	28		New 3	lersey
land	Mo TH		10a. State 10b. Coun	ty		10c. (	City, Town or L	ocation							1	0d. Inside City Limits
Man	filed the	tor	DE K	ent		Har	ringto	n							i	1 ☐ Yes 2¼☐ No
h the	or 28g	Director	10e. Street and Number			1		10f. Zip	Code				10g. C	itizen of	What Cour	ntry?
th wi	23a (	ain	40 Pleasant P	ine C	ourt			199	952				usa	ì		
r dea	swe.	Funeral	11. Marital Status	1	2. Was Deced Armed Ford	lent Ever in	U.S. 13.	Was Deced	lent of Hi	spanic Ori	igin? (Spi	ecify Yes or t Rican, etc.)	10-		ce - Americ	
s afte	or in	by Fu	1 Never Married 2 M		1 ☐ Yes 2 If Yes, Give			1 ☐ Yes						Speci	fv:	
5-UU36 72 hours after death with the Maryland	nene. r than "natural", or liems 23a or 28a-f show Ire Medical Examinal must be notified at		¥XWidowed 4 □ Divorce 15. Decede		Year or Dat	tes:	150 Door	dent's Usua					1 405		WI	nite
	an" n	Completed	(Specify only high	est grade	completed)		(Give	kind of wor DO NOT us	rk done d se retired	luring mos }	t of work	ing	160.	ring of E	Business/In	dustry
within	Hygiene. other than ent, It e M	lmo	Elementary/Secondary (0-12	'	College (1-	4or 5+)		usewii		,			F	Iome		
S pliled	othe othe	Bec	17. Father's Name (First, Middl	, Last)						18. Mothe	er's Name	e (First, Midd	le, Maide	n Suma	me)	
Maryland d 2 should be file	0 0	ToB	John Garrett							Lil	lian	. (Est	$e11\epsilon$	2)		
1 <b>ar</b> ) 2 sho	and Is me		19a. Informant's Name/Relatio				19b. Maili	ng Address	(Street a	and Numbe	er or Rura	al Route Num	ber, City	or Town	, State, Zip	Code)
	Health tem 27 I		Sharon Reynold	s-Dau	ghter		_	leasaı		ine C	Court	Harr	ingt	on,	DE 19	9952
<u> </u>			20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation	1 3 □Re	moval from S		Place of Disponentery, cre	osition (Nan matory or o	ne of ther place	θ)	[	Date	20c.	Location	- City or To	wn, State
Pag.	tant: jury o		`4 ☐ Donation 5 ☐ Other	(Specify)			arratts				-20-	05	Fre	deri	ica, I	ÞΕ
Sall ermit	Department of Important: If i any injury or once.		21. Signature of Funeral Service	e License	9	1		2. Name an				Melvin				
<u> </u>	_ = a a		nonu-	2.	Me			5522						on,	DE 19	
Pny	ysician	)  }	23a. Part1. Enter the disease, shock, or heart failure. L Immediate Cause (Final disease or condition	st only on	e cause on ea	ch line.	ALTERY	1150						12		Approximate Interval Between Onset and Death
	ledical aminer		resulting in death)		Due to (o	r as a cons	equence of):		- (	, , , , , , ,	- 4	GIZENTA				( )
	animici	_	Sequentially list conditions,	b.		DIDNY		MITT	M.	Mu	E NE	C-126174	16N			JEMS
pe	ısıt	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	₹	·	r as a cons	- 2	0	A constant							00400
хөсп	sician and burial-transit	Examiner	that initiated events resulting in death) Last	C.		r as a cons	ACTERLE	/ US	- Jan. 12					-		y engs
ate be ex	ysician ne burial	calE		l.												
00 I				- a.												
Goath certificate be executed	attending phy I for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23	c. If yes, outco									23d. Da	ate of delive	ary
death a	e atte	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No		4□Pregna	th 2 Fe int at time of		□Ectopic pro □ Other (sp.						М	onth	Day Year
at the C	ed by the a	hys	9 🗌 Unknown		9□ Unknov	₩n										
3s #	gned be de	by F	Part II. Other significant cond	tions con	tributing to dea	ath but not re	esulting in the u	inderlying ca	ause give	en in Part I		23e. Did	tobacco	use con	tribute to th	ne cause of death?
ora equir	been si											10	] Yes	2 🗌 No	3 🗌 Prob	ably 4 Unknown
Record he law require	SCA	Completed										24a. Wa	s an	24b.	Were auto	psy findings available
	ate	Con										per	formed? 2⊡K	lo l	death?	2 No
VITAI siclan: T	nis certificate director, pag	Be	25. Was case referred to medi examiner?	_							of Death	n (Check onl)	one)			
of Vita Physician:	this al di	ို	1 Yes 2 No	H			☐ ER/Outpatie	-	-	4 111	-	me 5 Re				y)
	fter	Certification;	27. Manner of Death 1 ⊟Natural 5 □ Pen		28a. Date of (Month	, Day Year)	28b. Time o Injury		8c. Injury Work	(?		28d. Describ	e how inj	ury occu	rred	
DIVISION For Attending	deatl	icat	3 ☐ Suicide 6 ☐ Cou		290 Place 6	of Injune - At	home, farm, st	M factor		Yes 2□	-	20f Location	/Street	and Alcom	has as Chie	J. Courte Mireshore
> ×	in by	ertif	4 Homicide dete	mined	building	g, etc. (Spe	city)	reet, ractory	, опісе			City or T	own, Sta	te)	oer or Hura	l Route Number,
DIVISION the Hospital or Attending	within 24 hours a <b>To the Funeral I</b> completely filled		29a. Certifier 1 ☐ Certif	ring Phys	ician: To the h	oest of mv k	nowledge, dea	th occurred	at the tim	ie, date ar	nd place	and due to th	A Causel	s) and m	anner as a	lated
e Hos	e Fur	Medical	(Check only 2 Medic	al Examin	er: On the bas	sis of exami	nation and/or in	ivestigation,	in my op	pinion, dea	ith occurr	ed at the time	e, date a	nd place,	and due to	the cause(s)
To the	withir To th comp	Me	29b Signature and title o certi	ier				290	. License	number		,	29d. D	ate signe	edy(Month,	Day, Year)
-			K 1	1					Di	535	551			41	17/20	05
			30. Name and address of person	n who cor	npleted cause	of death (It	em 23a) (Type	Print)			,			1	1	
		7	James Toda		7.0.	100	em 23a) (Туре Е. СА	KROH	51	·`	30/1	shung	Me	2		
	Sta		31. Date filed (Month, Day, Yea	ır)	32. Re	gistrar's Sig						,				
Li	Registr	ar	APR 2 1	2005	1 House	Postar a	K do	and I								

DHMH 17 Rev 1/2001

128-20-2846

Deignan Stan

			For State Registrar	State of M	aryland / Depa	artment of H			giene () (	05 14320	
	Physici /Medio		Decedent's Name (First, Middle, Last     Charles	Lee	Elliott			2. Date of Dea Month	Day 12. 200	Year 9:00 N	
	Examir		4a. Facility Name (If not institution, give  1103 S. Schumake: 5. Social Security Number 6. Se	r Dr., Ap	t. 202	4b. City, Town, or Salisb		h	4c. Count	ty of Death	
	Funeral Director			20 A O D E	ge (In yrs. last birthday)  Yrs.	Months Days	Hours Min.	8. Date of Birt (Month, Da) 8/19/1	y, Ye <i>ar)</i> 919	9. Birthplace (State or Foreig Country) Maryland	in —_
	the Maryland 28a-f show	rector	10a. State 10b. County  Maryland Wicomico  10e. Street and Number	>	10c. City, Town or Lo				10a. Citizen of	10d. Inside City Limit: 1 ☐ Yes 2 🖫 No	
	3e or	Ö	1103 S. Schumake	er Dr., A	nt. 202	2180	4		USA	· · · · · · · · · · · · · · · · · · ·	
920	ges 1 and 2 should be filed within 72 hours after death with the Maryland to f Heelih and Mental Hygiene. If item 27 is marked other than "natural", or items 23e or 28a-f show or other traumatic event. The Madical Examiner must be natilised at	by Funeral Director	11. Marital Status  1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent	Ever in U.S. 13.	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	ispanic Origin? (S in, Mexican, Puer	pecify Yes or No- to Rican, etc.)		ace - American Indian, ack, White, etc. ify: white	
21215-0036	d within 72 ho giene. er then "natur i fre Modical"	Completed	15. Decedent's Ed. (Specify only highest grad Elementary/Secondary (0-12) 12	cation	5+) 16a. Dece (Give life.	dent's Usual Occup kind of work done o DO NOT use retired nager	ation during most of wor l)	rking		Business/Industry  Can Plant	
Maryland	2 should be filed withir and Mental Hygiene. Is marked other than aumatic event, the M.	To Be C	17. Father's Name (First, Middle, Last)  Marvin Lee Ellio	t			18. Mother's Nar Ruth Me	пе (First, Middle, essick	Maiden Suma	ame)	
	i and 2 sho feelth and im 27 is m ther traum		19a. Informant's Name/Relationship (T)  Virginia W. Ellion  20a. Method of Disposition			S Schuma				n, State, Zip Code)  DUTY MD 21804  City or Town, State	
Baltimore,	Pe nen		1 🖫 Burial 2 □ Cremation 3 □ I • 4 □ Donation 5 □ Other (Specify,		Parsons	Cemetery	4/1			ury, MD	
Bal	permit. Departr Importe any inju		21 Signature of Funeral Service Licens  Own 4. Ukor	mornin	CFSP E	01 Snow F	Funeral H	, Salisb	ury, MD		
8760,	Cate be executed hysician and physician and physician and the burial-transit the burial-transit	dicai Examiner	23a. Part1. Enter the disease, or composhock, or heart failure. List only of immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or a:	on 125 Five	e Heart Fic Hear	Failur + Ds.	<		Approximate Interval Between Onset and Death	
P.O. Box 6	The law requires that the death certific ate has been signed by the attending p page 2 should be detached for use as	Completed by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		2 Fetal death 3	⊒Ectopic pregnancy ]Other (specify)				ate of delivery Ionth Day Year	
Records, P	w requires that the been signed by should be detac	ted by PI	Part II. Other significant conditions co	ntributing to death	1 / /-	nderlying cause give	. /		obacco use cor ∕es 2 ☐ No	ntribute to the cause of death?	n
al Reco		Comple	Hyperlipidema,	Hyper	-Vension					. Were autopsy findings availabl prior to completion of cause of death? 1  Yes 2  PNo	9
on of Vital	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director.	tion: To Be	25. Was case referred to medical examiner?  1 Yes 25000  27. Manner of Death  1 NoNatural 5 Pending investigation	Hospital: 1  lnpat 28a. Date of Inj (Month, D		f 28c. Injun Work	er: 4 Nursing H	ath <i>(Check only o</i> lome 5 <b>©</b> Residence 1	dence 6 🗆 Ot		
Division	To the Hospitel or Attending Phy within 24 hours after death. To the Funerel Director: After thi completely filled in by the funeral	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Ir building, e	njury - At home, farm, st tc. (Specify)	reet, factory, office		28f. Location (S City or Tox	Street and Num vn, State)	nber or Rural Route Number,	
	the Hospi in 24 hour the Funer pletely fills	Medical	(Check only 2 Medical Exam	sician: To the bes iner: On the basis and manner s	t of my knowledge, deat of examination and/or in tated.	vestigation, in my o	pinion, death occu	a, and due to the curred at the time,	cause(s) and m date and place	nanner as stated. , and due to the cause(s)	
	S C S	2	29b. Signature and title of certifier	) my		29c. Licens	4986		4/14	ed (Month, Day, Year)	
	1,18	And the second s	30. Name and address of person who of Robert J. Reilly	mp 560	Riverside Dr	Print) & Bloi Sal.	isbury A	1d- 218	0/		
	Sta Regist		31. Date filed (Month, Day, Year) APR 1 5 2	005 32. Hasis	trar's Signature	harle					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend items 23b, 26 per phys 842 4-27-05 vt.

State of Maryland Poepariment of Health and Mental Hygiene 1 - For State Registrer Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** MARCH 10 6525 Velyn Fleegle 1 2005 /Medical Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Medical Contr Maryland If Under 1 Year If Under 24 Hrs.
Months Days Hours Min BALTIMER 8. Date of Birth (Month, Day, Year) APR• 14,1922 9. Birthplace (State or Foreign Country) WEST VIRGINIA 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months 1 M M 300 F 215-12-2587 82 Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits urel', or Items 23a or 28e-f show LETST: It or ITUSI be notified at 1 ☐ Yes 2 No ALLEGANY LAVALE MD Directo 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1128 BRADDOCK ROAD 21502 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status filed within 72 hours after 1 ☐ Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2X Married 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: by Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced "neturel", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. HOME HOMEMAKER 8 and Mental Hygie le marked other permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 Is marked othe any injury or other treumetic event, ONR. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be CLARA MAY BARNCORD THOMAS ARLINGTON BOOTMAN ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) SHEILA R. EVANS / DAUGHTER 111 BOYER ROAD, FORT VALLEY, VA 22652-2041 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Name 
■ Burial 2 □ Cremation 3 □ Removal from State RESTLAWN MEML.GARDENS03/14/2005 LAVALE, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
UPCHURCH FUNERAL HOME, P.A. church 202 GREENE ST., CUMBERLAND, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Filysician Hemorrage /Medical Due to (or as a consequence of): Abdominal Aortic Aneurysm **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760. attending physician by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month Year in the past 12 months? 4 Pregnant at time of death 5 Other (specify) P. 0. the detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed 1 ☐ Yes 2 ☐ No 2 No of Vital Hospitel or Attending Physicien: director. 25. Was case referred to medical examiner?

1 ★ Yes 2 ☐ No Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence (Specify) 2 1 Inpatient 2 ER/Outpatient 3 DOA this in by the funeral 28a. Date of Injury (Month, Day Year) 27. Vanner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Division 1 Natural 2 ☐ Accident 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 | Homicide within 24 hours a To the Funerel C pellil Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MARCH 10, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Greene St, Stitume MS 21201 3 MP Masew

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

ORIGINAL

32. Registrar's Signature

NK KG	05-	2535		State of Maryland / Department of Health and No. 1 - State Registrar Amend #24a & b.Per MED PCC 4-14-05 Cartificate of Death		ene 005	14322		
		Physicia	an	1. Decedent's Name (First, Middle, Last)	2. Date of Death Month	Day Year	3. Time of Death		
		/Medic	al	Woneaundera Gilliam  4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death	April 1	11, 2005 4c. County of Deat	8:17 A M		
		Examin	er	Prince George's Hospital Center Cheverly			"George's		
		Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day,	Year) 9. Birt	hplace (State or Foreign		
		Director		433-27-0820 43 Yrs. Usual Residence of Decedent	Apr. 1,	1962 L	ouisiana		
		yland		10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits		
		e Mar Ba-f sl	Director	DC Washingt	on		1 XYes 2 No		
		with the	Dire	10e. Street and Number 10f. Zip Code	10	og. Citizen of What Co	-		
		na 23	erai	2031 - 36th St., S.E.  20020  11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	pecify Yes or No-	United States  14. Race - American Indian,			
	ဖွ	after or Item	by Funerai	Armed Forces?  1 Never Married 2 Married  1 Yes 2 No  1 Yes 2 No  1 Yes 2 No  1 Yes 2 No  1 Yes 2 No  1 Yes 2 No  1 Yes 2 No  1 Yes 2 No  1 Yes 2 No  1 Yes 2 No  1 Yes 2 No  1 Yes 2 No	Rican, etc.)	Specify: Black			
	Maryland 21215-0036	hours tural',	d b		1 -				
	-5	iln 72 n "nat	Completed	15. Decedent's Education (Specify only highest grade completed)  [Second Second	king	16b. Kind of Business/Industry			
	212	d 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. 77 is marked other than "natural", or items 23s or 28s-f show traumatic avant. It a Medical Evariant final by incities at	Com	Elementary/Secondary (0-12) College (1-4or 5+) 4 Community Devel	oper	Gover	nment		
	pu	be file ital Hy id oth avant	Be		e (First, Middle, M				
	<u> </u>	hould d Men narka natic	P	Fate Pouncy  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Run		Rosa Gilliam			
	Ma	permit, Pages 1 and 2 s Department of Health an important: If itam 27 is r any injury or other traun once.		Ronald Gilliam - Brother  510 Crazy Horse, Har					
	re,	s 1 ar of Hea itam othar	1	20a. Method of Disposition 20b. Place of Disposition (Name of		20c. Location - City or			
	Baltimore,	Page ment c ant: if ury or		I CA DUISI 2 COMMANDI 3 CHAMOVALION STATE	6/2005	Shrevepo	rt, LA		
	3alt	ermit, Jeparti nporti ny inj				uneral Hom			
		ZO := 6 0		23a. Party. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line.			20019 Approximate		
	8760,	Physician /Medical Examiner	dicai Examiner	Immediate Cause (Final disease or scholition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  C. Due to (or as a consequence of):			Interval Between Onset and Death		
	.O. Box 6	To the Hospital or Attanding Physician: The law requires that the death certific within 24 hours after death.  To tha Funaral Diractor: After this certificate has been signed by the attending prompletely filled in by the funeral director, page 2 should be detached for use as a	Physician/Me	IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9  Unknown  23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown  23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 5 Other (specify)		23d. Date of del Month	ivery Day Year		
	rds, P	w requires that been signed b should be deta	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tob	acco use contribute to s 2 No 3 ☐ Pr	o the cause of death?		
	Division of Vital Records, P.O.	siclan: The law re certificate has be irector, page 2 sh	Completed		24a. Was an autopsy perform	24b. Were au prior to death?	utopsy findings available completion of cause of		
	Vita	ding Physician: The h. h. After this certificate ha funeral director, page	Be	examiner/	th (Check only one				
	of	Phys r this eral dir	: To	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at	28d. Describe how	w injury occurred			
	ion	Attanding death. ctor: Afte y the fune	ation:	1 □ Natural 5 □ Pending (Month, Day Year) Injury Work?  2 🌣 Accident investigation 4 - 11 - 05 7 - 30 A M 1 □ Yes 2 🗖 No	Pedestriam	struck b	of a motor		
	ivis	r Atta ler de iracto l by th	ertific	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Str.	reet and Number or Ru , State) Switte	ral Route Number.		
		pital o urs aft sral Di illed in	0	Road	Southern A.	ve Wishing	on DC		
		e Hos 24 ho a Funi	ledical	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place,  (Check only one)  Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occur  and manner stated.	, and due to the ca rred at the time, da	use(s) and manner as ite and place, and due	s stated. to the cause(s)		
4		To the Hospital or Attandii within 24 hours after death. To tha Funaral Diractor: Al completely filled in by the fu	Me	29b. Signature and title of certifier  29c. License number  OCME		9d. Date signed (Mont. pril 12, 2			
	0	(6)		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)					
(	1			LING LI, M.D 111 Penn Stre	et Balti	Lmore, Mar	yland 21201		
		Sta Regist		31. Date filed (Month, Day, Year)  APR 1 4 2005  33. Registrar's Signature					

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death **Physician** Ruth Marie /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** ambrida omhester If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Month Days | Hours | Min. | May 1, 1937 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 1 E 67 215-74-5144 Yrs. Director Maryl Usual Residence of Decedent 10h Counts 10d. Inside City Limits 10a State 10c. City, Town or Location MD Dorchester Director Hurlock XTYes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 106 Elm Street United States 21643 Funera 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1√ Never Married 2 Married Baltimore. Maryland 21215-0036 1 Yes 2 No White Completed by 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) N/A N/A and Mental Hygier is marked other th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 99 Stanley Edwin Hope Margaret Mary Jervis 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Importent: If item 27 is any injury or other tree once. 29022 Johnson's Drive, Seaford, DE 19973 Samuel E. Hope/Brother 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Unity-Washington Cem. 04/13/05 A □ Donation 5 □ Other (Specify) Hurlock, Maryland 22. Name and Address of Facility Framptom Funeral Home, P.A. 21. Signature of Funeral Service Licenses Erken 216 N. Main St., Federalsburg, MD 21632 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examine it any leading to immedicause. Enter Underlying Cause (Disease or injury The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): burial-1 Box 68760 Physician/Medical the attending p IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month 4 ☐ Pregnant at time of death 5 Other (specify) P.O. 1 Yes 2 Thio Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ he has dation 3 Probably 4 Unknown 1 Yes 2 No Be Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? has certificate 20No 1 ☐ Yes 1 TYes 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 2 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 28c. Injury at Work? 27. Manner of Death Dete of Injury Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending 2**0**No iration death. COAM 1 🗌 Yes investigation 2 Accident

Division of Vital To the Hospitel or Attending Physician: after within 24 hours a To the Funerel I

> State Registrar.

Medical

Director:

6 Could not be determined

Suicide

29a. Certifier

4 Homicide

(Check only one)

Lugene 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier Umeu

30. Name and ad ress of person who



mpleted cause of death (Item 23a) (Type, Print)

Ø

1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated and manner stated.

29c. License number

29d. Date gigned (Month, Day, Year)

ocation (Street and Number or Rural Route City or Town, State)

Place of Injury - At home, farm, street factory, office building, etc. (Specify)

			1 - For State Registrar	State of Maryla			lealth and	Mental Hy	giene Reg. No. 005	14324		
	Physici	an	1. Decedent's Name (First, Middle, La	RUSSELL	11/1			2. Date of De Month	Day Ye	ar 1:25 PM		
	/Medic		VERNON  4a. Facility Name (If not institution, gi		V 14.	4h City Town o	r Location of Deat	04	4c. County of D			
	Examin	ier	Ruxton Health				ton		Carol			
	Funeral Director		5. Social Security Number 6.		. last birthday) 82 Yrs.		If Under 24 Hrs Hours Min.		rth 9.	9. Birthplace (State or Foreign Country) 1922 Maryland		
	w w		Usual Residence of Decedent  10a, State 10b, County	10c. C	ity, Town or Lo	ocation				10d. Inside City Limits		
	the Maryl 28a-f sho	ector	,	oline		Pres	ton			1 ☐ Yes 2 ☐ No		
	3a or	i Dir	7244 Harmony	Road		10f. Zip Code	655		10g. Citizen of What United S	•		
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or items 23a or 28a-f show any njury or other traumatic event, the Medical Exatt that must be indiffied at ance.	by Funeral Director	11. Marital Status  **X_Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in I Armed Forces? 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 No	lispanic Origin? (S an, Mexican, Puer Specify:	Specify Yes or No to Rican, etc.)	14. Race - A Black, W Specify:	mencan Indian, Jhite, etc. White		
Maryland 21215-0036	vithin 72 ho ne. han "natur e Medical	Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)		(Give	dent's Usual Occup kind of work done DO NOT use retired	during most of wo	rking	16b. Kind of Busine			
d 21	filed w Hygier other ti	e Col	17. Father's Name (First, Middle, Las	1)	Ma	chinist		me (First, Middle	, Maiden Sumame)	141		
<u>lan</u>	uld be Mental rrked c	To Be	Ernest Earl	Hall				aret Gi				
Mary	d 2 sho h and h 7 is ma trauma		19a. Informant's Name/Relationship						er, City or Town, State DE 1996			
Baltimore, I	ges 1 and t of Healt if item 2 or other		Hilda H. Jayw 20a. Method of Disposition 1   Burial 2 □ Cremation 3   [ Comparison of the comparison	20b.	Place of Dispo	osition (Name of matory or other place	ea)	Date	20c. Location - City	or Town, State		
ij	it. Pa ntmen ntant: njury		* 4 □ Donation 5 □ Other (Special Service Lice	97		Cemeter	1		Federals			
æ	Department of the control on the con		& Aristine	H. Coals	, 2	216 N. Ma:	in St., I	ederals	burg, MD 2	Home, P.A. 21632		
Į.	Pnysician /Medical		23a. Part1. Enter the disease, or cor shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	one cause on each line.	ith. Do not en	/	g, such as cardia		rrest,	Approximate Interval Between Opset and Death Hours		
8760,	Examiner	ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conse	SLLER quence of): WOLE	OTIL CA		sculge	DSEMSE	YEARS YEARS		
P.O. Box 68	the death certific by the attending p ached for use as	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of 9 ☐ Unknown	al death 3	Ectopic pregnancy			23d. Date of Month	delivery Day Year		
	w requires that been signed b should be deta	by	Part II. Other significant conditions  HYPERTEN	USION ALZ	sulting in the u	110	en in Part I.	23e. Did t		o to the cause of death?  Probably 4 Unknown		
Vital Records,	The ate h page	Completed	ATHEROEM	BOLLL Dist	USE			24a. Was autop perfo				
Vita	yeiclan: The is certificate hadirector, page	Be	25. Was case referred to medical examiner?	Hospital:		0.15	12.00	th Check on c	one			
Division of	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific, completely filled in by the funeral director,	tion: To	1 Yes 2 No  27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	f 28c. Injun Worl	4 Nursing H		dence 6 Other (S	pecify)		
Divisi	al or Attending safter death. I Diractor: After sd in by the funer	Certification:	3 Suicide 6 Could not l	De 200 Blace of Injury At h	nome, farm, str	eet, factory, office		28f. Location (S City or Tox	Street and Number or wn, State)	Rural Route Number,		
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Diractor: After th completely filled in by the funeral	edical	29a. Certifier (Check only one)  1 Certifying P 2 Medical Exa	hysician: To the best of my kn miner: On the basis of examin and manner stated.	owledge, deat ation and/or in	n occurred at the time vestigation, in my of	ne, date and place pinion, death occu	, and due to the rred at the time,	cause(s) and manner date and place, and d	as stated. lue to the cause(s)		
	To t To t	Σ	29b. Signature and title of certifier	ATTS	NOING	29c. License	number	GII	29d. Date signed (Mo			
,			20 Name and address of	completed assess of the time	MD	Deint)	10731	274	04/08/	2007		
			30. Name and address of person who 321 Boomin			-ALSBY	6, MT	> 21(	032			
	Sta Registr		31. Date filed (Month, Day, Year) APR 1 2 21	32. Fegistrar's Sign		ad F	14					

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in	Black Indelible Ink.	Ensure All Copi	es Are Legible.

			1 - For State Registrer	State of Maryland		nent of He			giene Reg. No.		143	25
	Physici		Decedent's Name (First, Middle, La		·			2. Date of Dea Month April	ath Day	2005	3. Time of 0	Death <b>a</b> M
	/Medio Examin		Charles Ham1  4a. Fecility Name (If not institution, given		4b.	City, Town, or L	ocation of Death			County of Deat		
	LAGIIII		Laurel Regiona			aurel			P	rince	George	
	Funeral		5. Social Security Number 6. S	Sex 7. Age (In yrs. las	st birthday) If		If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da	h v Year)	9. Birtl	nplace (State or untry)	Foreign
	Director		245-22-9044 Usual Residence of Decedent	<sup>™</sup> <sup>2□</sup> F 79	Yrs.	Day's	Tiodis Will.	June 1	4,1	925 No	orth Ca	rol
	yland iow		10a. State 10b. County	10c. City,	Town or Location	n					10d. Inside City	/ Limits
	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Merial Hygiene. Item 27 is marked other then "neturel", or Items 23a or 28a-f ehow other traumatic event, the Medical Examinal must be notilied at	Funeral Director	Md. Prince	George Lau	rel						1XX Yes	2 🗌 No
	ith the	Dire	10e. Street and Number		11	Of. Zip Code			10g. Citi:	zen of What Co	untry?	
	ath w	ra I	14200 Laurel Pa			20707			USA			
	er de Items	nue	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	. 13. Was	Decedent of Hisp s, specify Cuban,	panic Origin? (Sr , Mexican, Puerto	pecify Yes or No Rican, etc.)	•	<ol> <li>14. Race - Ame Black, White</li> </ol>		
36	irs aft	by F	1 ☐ Never Married 2 ☐ Married  3X Widowed 4 ☐ Divorced	12∑Yes 2 ☐ No If Yes, Give Year or Dates:	10	∕es 2⊠No	Specify:			Specify: Bla	ck	
21215-0036	2 hou	ted	15. Decedent's E	ducation		Usual Occupati			16b. Kir	nd of Business/		
215	hin 7:	Completed	(Specify only highest gr Elementary/Secondary (0-12)	College (1-4or 5+)	(Give kind life. DO N	of work done du. IOT use retired)	ring most of wor	king				
21	ad wit	Con	7thgrade	I	Exterm:					/Feder	al Gov	r't
pu	2 should be filed withir and Mental Hygiene. is marked other then aumatic event, the Ma	Be (	17. Father's Name (First, Middle, Last	)		1	8. Mother's Nam	ne (First, Middle,	Maiden	Sumame)		
<u>  \                                   </u>	should be Ind Mental I	ပို	Charles Hamli					Jnknowr				
Maryland	12 sh h and 7 is m rraum		19a. Informant's Name/Relationship	** * *	,	·		ral Route Numbe	. ,		ip Code)	
	1 and 2 Health tem 27		Peggy H. Edwar 20a. Method of Disposition	20b. Pla	ce of Disposition	(Name of		anham, M Date		0706 cation - City or	Fown, State	
Jor	0 0	ì	1 🔀 Burial 2 □ Cremation 3 [	Removal from State	netery, cremato	y or other place) EM Park		114,05				
Baltimore,			*4 □Donation 5 □ Other (Special Signature of Funeral Service Lice			me and Address		.114,00	ьа	ndover	Mu.	
Ba	permit. Departr Imports eny inju		It some	wienes	Marian Company			719 Ke	nne	đy St.	WW 20	011
	1231		23a. Paris Enter the disease, a c/n shop, or heart failure. List of h	positions that caused the reath.							Approximate Interval Betw	
	Physician		Immediate Cause (Final	9						Į	Onset and De	eath
	/Medical		disease or condition resulting in death)	a. Sepsis Due to (or as a conseque	ence of):							
	Examiner		Sequentially list conditions	<sub>b.</sub> Pneumonia								
	p #	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseque	ence of):							
	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c Due to (or as a conseque	anno of):							
8760,	cian a			Due to (or as a conseque	ance or,							
87	physi the t	Physician/Medical	•	d								
9 x	eath certifica attending pl	/Me	IF FEMALE:	23c. If yes, outcome of pregnand	су				2	23d. Date of deli	varv	
Вох	atter I for u	ciar	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 2 ☐ Fetal d 4 ☐ Pregnant at time of dea		opic pregnancy er <i>(specify)</i>				Month	•	ear
P.O.	that the de ned by the a detached t	hysi	9 Unknown	9□ Unknown				- 0.				
σ,	res that igned to be det	by P	Part II. Other significant conditions	contributing to death but not result	ting in the under	ying cause given	in Part I.	23e. Did to	obacco u	se contribute to	the cause of de	ath?
Records,	w require been sig should b	edk	Multiple my	loma				1 🗆 \	/es 2[	□No 3 □ Pro	obably 4 XUr	iknown
000	aw requ is been 2 should	Completed	Renal Failu	re				24a. Was		24b. Were au	topsy findings av	vailable
R	The law ate has page 2 s	mo;						perfo	rmed?	death?	2 □ No	130 01
Vital	yeicien: Th is certificate director, pag	Be (	25. Was case referred to medical examiner?				26. Place of Dea	th (Check only o	ne)			
of V	Ø .2 .5	Jo I	1 ☐ Yes 2X No	Hospital: 1₺Inpatient 2□E	R/Outpatient 3	□ DOA Other	4 ☐ Nursing H	ome 5 Resid	dence 6	Other (Spec	ify)	
ט		on:	27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury a Work?		28d. Describe h	now injury	y occurred		
sio	ten leat tor: the	catl	2 Accident investigation 3 Suicide 6 Could not to	10			es 2 No	OOA Leastine /6	Parent and	d N. 1		
Division	or At	Certification:	4 Homicide determined		ne, farm, street,	actory, office		City or Tox		d Number or Ru )	rai Houte Numbi	91,
	spitel ours a serel l		29a. Certifier 1 1 Certifying P	hysician: To the best of my know	ledge, death occ	urred at the time	. date and place	and due to the	cause(s)	and manner as	stated.	
	To the Hospitel or At within 24 hours after of To the Funerel Direct completely filled in by	Medical		miner: On the basis of examination and manner stated.								
	To the Hospitel within 24 hours a To the Funerel I completely filled	Me	29b. Signature and title of certifier			29c. License	number		29d. Date	e signed (Month	, Day, Year)	
			1877ey 6 N	10 Allewin	18.	D 425	580	A	pri	1 11,0	5	
0	(6)		30. Name and address of person who								20710	
K_	2		Parmjit Singh	Aujla, M.D.	5632 A	nnapol:	is Rd.S	Suite 1	3 B			ID
	Sta		31. Date filed (Month, Day, Year)  APR 1 4 2005	32. Registrar's Signatu	Least.							

			1 - For State Registrer	State of M	arylan		artment			and M		Reg. No	11111	)	143	26
	Physici	an	1. Decedent's Name <i>(First, Middle, Las</i> MARGARET HART	ſ							2. Date of De.	ath Day	y 0	ear	3. Time o	
	/Medio		4a. Facility Name (If not institution, give		)		4b. City,	Town, or	Location of	of Death	4		County of	005 Death	4:25	οA . "
		Ŭ.	GARRETT COUNT	Y MEMOR	IAL :			AKL/					ARRE	$\Gamma T$		
	Funeral Director		5. Social Security Number 6. Se 11	X 7. As	ge (In yrs. I	last birthday) 9 Yrs.	If Under Months	1 Year Days	If Under: Hours	24 Hrs. Min.	8. Date of Bird 10-28	th y. Year)	15 E	Birthp Coun LGI	lace (State of	or Foreign LL •
	9		Usual Residence of Decedent								10 20					
	farylar show	ō	10a. State 10b. County TUCKE	R	10c. City	y, Town or Lo								1	0d. Inside C 1 □ Yes	
	7 28a-1	Director	10e. Street and Number				10f. Zip	Code				10g. Cit	izen of Wh	at Coun		
	within 72 hours after death with the Maryland ene. than "natural", or items 23s or 28s-1 show fre Medical Exaction coal be notified at	ai D	PO BOX 668					2626	50				USA			
	items items	Funeral	11. Marital Status 1 □ Never Married 2 □ Married	12. Was Decedent Armed Forces? 1 ☐ Yes 2 📉	Ever in U.	S. 13. \	Was Deced f Yes, spec	ent of His ify Cubar	spanic Origin, Mexican	gin? (Spe , Puerto	cify Yes or No Rican, etc.)	-	14. Race - Black,	Americ White,		
036	ursaft al', or	کے	3 Widowed 4 □ Divorced	If Yes, Give Year or Dates:	NO		1 ☐ Yes 2	! □Xvo	Specify:				Specify:	VHI'	$\Gamma \mathrm{E}$	
21215-0036	72 ho	Completed	15. Decedent's Ed (Specify only highest grad	ucation de completed)		16a. Deced (Give	dent's Usua kind of wor DO NOT us	l Occupa k done di	tion uring most	of worki	ng	16b. K	ind of Busi	ness/Inc	lustry	
121	within iene. than	dwo	Elementary/Secondary (0-12)	College (1-4or	5+)	ASS	EMBL	e reti <b>re</b> a) Y L]	NE			WES	STIN	GHO	JSE	
pu	be filed ital Hygi id other event, II	BeC	17. Father's Name (First, Middle, Last)	37							(First, Middle,		Sumame)			
Maryland	should be found the found Mental I	٥	FRANK MISLE			405 14 75		(2)			A TOTI					
Mai	C1 00 00		19a. Informant's Name/Relationship (7 MARGE DORSEY/		R		BOX (				WV 26	5260		ate, ∠ip	Code)	
ore,			20a. Method of Disposition 1 □ Surial 2 □ Cremation 3 □	Damawal from Chata		lace of Dispo emetery, cren	sition (Nam	e of her place	a)	D	ate	20c. Lo	ocation - Ci	ty or To	wn, State	
Baltimore,			`4 □Donation 5 □ Other (Specify	)	P.	ISGAH				-21		FA]	ERMO	NΤ,	WV	
Bal	permit. Pag Department Important; any injury o		21. Signature of Furteral Service Licens	inkle		22	HINKI PO BO	EE F	UNE 86,	AL DAV	HOME, IS WV	INC 26	5260			
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final	lications that cause ne cause on each I	d the death ine.	,		-	-						Approximat Interval Bet Onset and	e ween Death
	Physician /Medical		disease or condition resulting in death)	a. CUL	a consequ	uence of):	Dra	500	Rai	ac	ade	X		٥	2 wee	as
	Examiner		Sequentially list conditions	ather	050	levos	is				-				year	3
V	ed sit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that is it and exercise)	Due to (or as	a consequ	uence at):									1,001	~
,	execut n and iai-trar	Examiner	that initiated events resulting in death) Last	c. Due to (or as	a consequ	uence of):	5	1							teas	ے
8760,	sate be executed bhysician and the burial-transit	dicai	(	a. emph	ypen	na i	with	hy	POX	lu	ia & h	MA	25 Cly	Dia	pell	ess
9	The law requires that the death certificate be executed the has been signed by the attending physician and tage 2 should be detached for use as the burial-transit	/Med	IF FEMALE:	23c. If yes, outcome	of pregna	nev										
Box	death death death death death	Physician/Me	23b. Was decedent pregnant in the past 12 months?  1 □ Yes 2 □ No	1⊡Live birth 4⊡Pregnant a	2 Fetel	death 3	Ectopic pre Other (spe					Ι,	23d. Date o Month		-	Year
P.0	at the de by the	hys	9 Unknown	9∐Unknown			-1/2 - 1/1		··		Т					
	signed to be det	þ	Part II. Dther significant conditions co	ntributing to death t	out not resu	ulting in the ur	nderlying ca	use give	n in Part I.	J. T.	23e. Did to				e cause of o ably 4 ⊡l	
COL	w require been si should b	iete	Stiruse disa	olos	Do.	a part	7 5100			) u	24a. Was				sy findings	
of Vital Records,	The lav	Completed	sugar our	1	a		700				autop perfor		pridea	r to com	ipletion of c 2 □ No	ause of
/ita	Phyaician: T r this certifical ral director, p	Be	25. Was case referred to medical examiner?	Janailali N. A						of Death	(Check only o	/>				
of	Phya rthis raldii	); To	1 ☐ Yes 2 No 27. Manner of Death	Hospital: 1 Linpation 28a. Date of Inju		ER/Outpatien 28b. Time of		A Other Bc. Injury Work	4 🔲 Nui	sing Hon	ne 5 🗆 Resid			(Specify	)	
ion	ttending Phy death. ctor: After thi y the funeral o	atior	1 Natural 5 ☐ Pending 2 Accident investigation	(Month, Da	y Year)	Injury	м		? es 2 □ M	40						
Division	or Attending after death. Director: Aftel in by the fune	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of In building, e			eet, factory,	office	-	2	8f. Location (S City or Tow	Street and nn, State	d Number )	or Rural	Route Num	ber,
_	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical Ce	(Check only Z Madicel Exem	sicien: To the best	of examinat	wledge, death	occurred a	it the time	e, date and inion, deat	place, a	and due to the o	cause(s) date and	and mann place, and	er as sta	ited. the cause(s	)
	Fo the vithin ?	Mec	29b. Signature and title of certifier	and manner st	a1 <del>0</del> U.		29c.	License	number		1	29d. Dat	e signed (/	Month, E	ay, Year)	
	>- 0		Murganet	a Ka	un	N	17	26	650	Ò		1	4/19	/20	05	
	Œ		30. Name and address of person whore	ompleted cause of o	death (item		rint)	Carl	1 = 1	) .		11	1		1215	-
	Sta	te	31. Date filed (Month, Day, Year)	32 Registr	rar's Signat	(307) ture	1 gar	rest	night	nua	4,00	Kla	rud,	Mc	1215	50
	Registr			05 Back	wh	1. Light	SALI		)	/						

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Day Yeer **Physician** 12:45 AMM KATHRYN IDA **JESTER** April 2005 /Medical 4a. Facility Name (If not institution, give street and number)
Wicomico Nursing Home 4b. City, Town, or Location of Death Salisbury 4c. County of Deeth Examiner Wicomico If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) MAR.11, 1913 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 9. Birthplace (State or Foreign **Funeral** 1 ☐ M 2 F DELAWARE 222-09-1388 92 Director Usual Residence of Decedent 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits 28a-f ahow other traumatic avant, the Medical Examiner must be notified at WICOMICO FRUITLAND 1X Yes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 117 HAYWARD AVE. 21826 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 【No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ö 1 ☐ Yes 2 🛣 No Specify: Specify: 3 Widowed 4 □ Divorced WHITE Year or Dates: "natural" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) itam 27 la marked other than College (1-4or 5+) HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 1 and 2 should be Health end Mental RAYMOND TUCKER VERDA O'DAY 2 W. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DORIS E. SMITH - DAUGHTER P.O. BOX 342, FRUITLAND, MD 21826 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If Ita any injury or ot 1 X Burial 2 Cremation 3 Removal from State MILFORD COMMUNITY CEM.4-20-05 MILFORD. DE \*4 □Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SHORT FUNERAL SERVICES MILTON, DE 19968 rosem. 416 FEDERAL ST.. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause op\_each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examine certificate be executed burial-transit and Due to (or as a consequence of): the attending physicien Box 68760, Physician/Medical as the IF FEMALE: use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy jo Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. 1 ☐ Yes 2 ☑No detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š Records, 99 IBRILLATION 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐⊌fiknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? certificate CHRONIC 1 Yes 2 No Division of Vital Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 V Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 2 2 ER/Outpatient 3 DOA this To the Funeral Diractor: After th completely filled in by the funeral 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: or Attanding 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital 1 (Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D-0060515 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mahesha Thimmarayappa M.D. 614 Easternshore Dr Salisbury MD 21804 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

**ORIGINAL** 

			1 - For State Registrar	State of	Maryland /		artmen rtificate				lental Hy	giene Reg. No.	005	14328	3
	Physic	ian	Decedent's Name (First, Middle, La	st)	EC						2. Date of De		Year	3. Time of Death	_
	/Medi	cal	FRANK	1,00				- 10			04	11	2005	3:001 N	1
	Exami	ner	4a. Facility Name (If not institution, giv	l Media.	_		4b. City,	10wn, or	Location of			4c. Cou	unty of Death		
	Funeral	_	5. Social Security Number 6. S	Sex 7.	Age (In yrs. last		If Under		If Under	24 Hrs.	8. Date of Bi	rth	None	Dlace (State or Foreigntry)	ın
	Director		013 24 9/68	IXM 2□F	96	Yrs.	Months	Days	Hours	Min.	(Month, Da Feb 12			sachusetts	
	land ow		Usual Residence of Decedent  10a. State 10b. County		10c. City, To	own or Lo	cation							10d. Inside City Limits	
	Marylan a-f show	tor	MD Baltimo	ore	Cator	nevri 1	۵۱۵							1 ☐ Yes 2 No	
	or 28,	Funeral Director	10e. Street and Number		Cacon	TO ( T)	10f. Zip	Code				10g. Citizen	of What Cour	ntry?	_
	ath w	ral	707 Maiden Choice					21228					ted Sta	ates	
	items items	une	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decede Armed Force 1 Yes 2	es?	13.	Was Deced If Yes, spec	ent of Hi	spanic Ori n, Mexican	gin? (Spe i, Puerto	ecify Yes or No Rican, etc.)	o- 14. I	Race - Americ Black, White,		
5-0036	72 hours efter death with the Maryland naturel', or items 23a or 28a-f show Jisal Evaninspruut be rodiffed at	by	3 Widowed 4 Divorced	If Yes, Give Year or Date	s: 1943–45	5	1□ Yes 2	No No	Specify:			Spe	ecify: Whi	ite	
5-0	72 ho	Completed	15. Decedent's E	ducation ade completed)	16	Sa. Deced	dent's Usua kind of wor	l Occupa	ition	t of worki	na	16b. Kind o	of Business/In		_
2121	within ene. than "	mpi	Elementary/Secondary (0-12)	College (1-4	or 5+)	life.	DO NOT us	e retired)		O WOINI		3.6		7.1	
	Hygie Hygie other t		17. Father's Name (First, Middle, Last,			CITE	ef of	POL		r's Name	(First, Middle	-		olice Dept	•
Maryland	2 should be filed withlr and Mental Hygiene. Is marked other than eumatic event, tre M	To Be	Tytus Kopec								a Wlody				
ary	2 shou and N is mai	-	19a. Informant's Name/Relationship (	Type, Print)	1:	9b. Mailir	ng Address				l Route Numb		wn, State, Zip	Code)	_
	and eelth n 27 ser tr		Frances Albert/Da	ughter	4	1509	Hemlo	ck C	one I		Ellicot	t City	, MD 2	21042	
Baltimore,	permit. Pages 1 Department of H. Importent: if itel any injury or ott		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 🗵	Removal from Sta	ile		sition (Nam natory or ot		- 1		ate		on - City or To		
Ħ	ift. Partmer intmer injury		<ul><li>4 □ Donation 5 □ Other (Specifical Service Licer)</li><li>21. Signature of Funeral Service Licer</li></ul>		St. S					4-16-	-2005	Adams,	Massa	chusetts	_
Ba	permit. Departr Importe any inju		Dem Colli	- 410	M01044	41		d Cc	12mh	Harı Harı	cy H. W	/itzke'	s Fami	ly FH Inc MD 21043	•
_			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caus	sed the death. D								CILY,	Approximate Interval Between	
	Physician	3 3	Immediate Cause (Final disease or condition		Inter	ere	GAN	Her	1ans	0				Onset and Death	
	/Medical Examiner		resulting in death)	Due to (or	as a consequenc	e of):	,,,,,	, ,	7						-
	_xamme.	100	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or	as a consequenc	e off:									
	unsit	Examiner	Cause (Disease or injury	200 10 (01	as a consequence	o ory.									
o,	execut an and rial-trar	Exa	that initiated events resulting in death) Last	C. Due to (or	as a consequenc	e of):									
8760,	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	dicai		d											
39 ×	ertifica Jing pl	Med	IF FEMALE:	00. 16				-							_
Вох	eath certific attending p	Physician/Me	23b. Was decedent pregnant in the past 12 months?		ne of pregnancy 2 ∏ Fetal dea tat time of death		Ectopic pre						Date of delive Month	ory Day Year	
0	at the de by the a stached t	hysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9☐ Unknowr		3_	JOINE (Spe	y)							
Q.	res that signed b	by Pl	Part II. Other significant conditions of	ontributing to death	n but not resulting	in the ur	nderlying ca	use give	n in Part I.		23e. Did t	obacco use c	ontribute to th	e cause of death?	
- G	w require been sig should b	ted									10,	Yes 2 10 No	3 ☐ Prob	abiy 4 Unknown	
of Vital Records,	e lawr has be je 2 sh	Completed						_			24a. Was		b. Were autop	psy findings available appletion of cause of	
al H		Son								_	perfo	rmed? 2 No	death? 1 🗌 Yes		
VII.	Physician: Th this certiticate ral director, pag	o Be	25. Was case referred to medical examiner?	Hospital:				Othe			(Check only o				
	g Physical dispersal di	ᄩ	27. Manner of Death	28a. Date of In (Month, I		. Time of		lc. Injury Work	4 🗀 1401		ne 5 🗌 Resid 8d. Describe I			′)	-
on	별드돌호	atio	1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigation		Day Year)	Injury	М		? es 2 □ N	No					
Division	of or Attendated atterdeath Director:	Certification;	3 ☐ Suicide 6 ☐ Could not be determined	280. Place of	Injury - At home, etc. (Specify)	farm, stre	et, factory,	office		2	8f. Location (8 City or Tov		mber or Rura	Route Number,	
Ω	spitel or ours attr nerel Dir tilled in			<u> </u>						//					i
	To the Hospitel or within 24 hours atte To the Funerel Director Completely tilled in the Funerel Director Completely tilled in the Funerel Total Completely tilled in the Fune	edical	29a. Certifier 1 Certifying Ph (Check only 2 Medicel Exan	ysicien: To the be niner: On the basis and manner	of examination a	ge, death and/or inv	occurred a restigation,	t the time in my opi	e, date and inion, deat	d place, a h occurre	nd due to the d at the time,	cause(s) and date and plac	manner as sta e, and due to	ated. the cause(s)	
	To the Hos within 24 h To the Fur completely	Me	29b. Signature and title of certifier	0.4.4			29c.	License	number			29d. Date sig	ned (Month, L	Day, Year)	_
			muren	Vlett	2		AU	417	643	5 MI	1014	4/11/	05		
3)00			30. Name and address of person who	completed cause o	death (Item 23a	) (Type, I	Print)					, ,			_
			Andrew Melt 31. Date filed (Month, Day, Year)	2 er	22 Sout	4 6	reev	051	1 B.	11	mue,	is	2/20	1/	_
	Sta Registr	_	APR 14 2	2005	death (Item 23a 22 South strar's Signature		seek)	f							

			1 - State Registrar	State of Marylan		artment of H rtificate of L		d Mental Hy	giene Reg. No.	112	14329
4		10	1. Decedent's Name (First, Middle, Last	)				2. Date of De			3. Time of Death
	Physicia		Beverly Kontos					April	11,	2005	2:00 P.M
	/Medic Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or	Location of D			County of Deeth	
	Examin	er	9912 Riverton R			Marde	la Spr:	ings		Wicomio	20
	Funeral		Social Security Number 6. Se		last birthday)	If Under 1 Year	If Under 24	Hrs. 8. Date of Bir	th		
	Funeral Director			DM 2123F 78	Yrs.	Months Days	Hours N	o2709/	4927	Ken	lace (State or Foreign try) Tucky
ļ ķ			Usual Residence of Decedent								
	ytanc sow		10a. State 10b. County	10c. Cit	y, Town or Lo	ocation				1	0d. Inside City Limits
	Man I ah	ţō	MD Wicomic	o Ma	ardela	Springs					1 ☐ Yes 2x No
	288 288	Director	10e. Street and Number			10f. Zip Code			10g. Citi	izen of What Cour	itry?
	3e o		9912 Riverton Roa	d		2183	7			USA	
	be filed within 72 hours after death with the Maryland ital Hygiene. d other then "natural", or items 23e or 28e-f ahow event, I'm Medical Examinat must be notified at	Funeral	11. Marital Status	12. Was Decedent Ever in U	.S. 13.	Was Decedent of Hi	spanic Origin	? (Specify Yes or No uerto Rican, etc.)	)-	14. Race - Americ	
^	r Her	F	1 ☐ Never Married 2 ☑ Married	Armed Forces? 1 ☐ Yes 2 No				uerto Hican, etc.)		Black, White,	
2	urs a	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 21X No	Specify:			Specify: WIN	ite
1215-0036	2 hou	ted	15. Decedent's Edu	cation	16a. Dece	dent's Usual Occupa	ation		16b. Ki	nd of Business/Inc	dustry
<u>.                                    </u>	in 7	Completed	(Specify only highest grad		(Give	kind of work done of DO NOT use retired	furing most of )	working			
7	with sene	E O	Elementary/Secondary (0-12)	College (1-4or 5+)	H	omemaker				Home	
Maryland 2	filled Hygi other	C	17. Father's Name (First, Middle, Last)		,		18. Mother's	Name (First, Middle	, Maiden	Sumame)	
a		To Be	Mont McVey				Εt	thel Delpl	n McV	<i>l</i> ey	
2	s 1 and 2 should be f Health and Menta item 27 is marked other traumatic ev	F	19a. Informant's Name/Relationship (T	voe. Print)	19b. Maili	ng Address (Street a	nd Number o	r Rural Route Numb	er. City o	r Town, State, Zip	Code)
<u>8</u>	d 2 sho th and 7 is m traum		George C. Kontos/					Mardela :			
	1 and 1 Health Iem 27	. 3	20a. Method of Disposition	20b. F	Place of Dispo	osition (Name of	1	Date	20c. Lo	cation - City or To	wn, State
ō	00		1⊠ Burial 2 ☐ Cremation 3 ☐ I	Removal from State	emetery, cre	matory or other place		/ /1/ /200E			
Baltimore,			* 4 ☐ Donation 5 ☐ Other (Specify,			of Faith		4/14/2005	вал	Ltimore,	
ğ	Departr Departr Importa any inju		21. Signature of Funeral Service Licens	99		2. Name and Addres		- 12 F	· · · · · · ·	Ch Dal	19940
<u> </u>	20E # 3	W 1	t. Twell	7				me 13 E. (		e St, Del	mar, DE
68760,	Physician be executed by physician and by physician and as the burial-transit	ledicai Examiner	23a. Part 1. Enter the disease, or come shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as a consequence)  Due to (or as a consequence)  Due to (or as a consequence)  Due to (or as a consequence)	uence of):  uence of):  uence of):	10		ECLITC			Interval Between Onset and Death
O. Box	res that the death certific igned by the attending p be detached for use as	Physiclan/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of d 9 □ Unknown	Ideath 3	□Ectopic pregnancy □ Other (specify)			4	23d. Date of delive Month	ory Day Year
٦.	law requires that the as been signed by th 2 should be detache	4	Part II. Other significant conditions co	ntributing to death but not res	ulting in the u	nderlying cause give	en in Part I.	23e. Did	tobacco u	ise contribute to th	e cause of death?
ds,	sign albe	1 by						1 🗆	Yes 2	No 3 □ Prob	ably 4 Unknown
0	w require been sig should t	Completed								The same of	
ec	e law has t	hdu						24a. Was	psy	prior to con	psy findings available mpletion of cause of
Y	Thate page	Son						1 ☐ Yes	ormed?	death?	2 🗆 No
Vital Records,	Physician: Th this certificate ral director, pag	Be (	25. Was case referred to medical examiner?				26. Place of	Death (Check only	one)		
	nysic IIS CE dire	2	1 ☐ Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatie	nt 3□ DOA Othe	er: 4 □ Nursir	ng Home 5 Res	idence (	6 □Other (Specif	/)
0	Attending Physician: or death. ector: After this certific by the funeral director.		27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time o	f 28c. Injury Work	at	28d. Describe	how injur	y occurred	
Division of	of or Attending Patter death.  Director: After if in by the funeral	atlo	1 Natural 5 Pending 2 Accident investigation			M 1 🗆 '	Yes 2 □ No				
N S	Atte	Ific	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At he building, etc. (Special	ome, farm, st	reet, factory, office	- 77	28f. Location City or To	Street an	d Number or Rura	l Route Number,
Ö	- 0 -	Certification:	- [] 100.1000	building, atc. (Spacin	"			J., G. 70	, 01410		
	To the Hospital of within 24 hours aff To the Funeral Discompletely filled in	Medical C		rsician: To the best of my kno iner: On the basis of examina and manner stated.							
	o th o th ompl	Me	29b. Signature and title of certifier			29c. License	number		29d. Dat	te signed (Month,	Day, Year)
	->-0				M	D50	759		04	4/13/2005	
	OB		30. Name and address of person who o	ompleted cours of death (1-	n 23a\ /Tun-	Print\					
	(-2		Charles Folashade	· · · · · · · · · · · · · · · · · · ·			alichu	ry. MD 219	801		
	V		31. Date filed (Month, Day, Year)	32. Rigistrar's Signa		LI Mui 9	ullovu.	-y, 1110 Z10	201		
1	Sta	ite	APR 1 3 2	105	4 /	Carl .					

DHMH 17 Rev 1/2001

ORIGINAL

			1 - For Stete Registrar		epartment of Health and Certificate of Death	d Mental Hygie	_
No.	Physic /Medi	cal	Decedent's Name (First, Middle, Las     Allison     4a. Fecility Name (If not institution, give	White Lee	4b. City, Town, or Location of De		Day Year 3. Time of Death 17, 2005 3:45 A <sup>M</sup> 4c. County of Death
	Examir Funeral Director	ier	Caroline Nursi 5. Social Security Number 6. Se	ng Home, Inc.	Denton	rs. 8. Date of Birth in. (Month, Day, Ye	Caroline  9. Birthplace (State or Foreign Country)
	pu »	tor	182-05-1063  Usual Residence of Decedent  10a. State 10b. County  Maryland Carol	10c. City, Town		April 27,	1908 New Jersey  10d. Inside City Limits 1 ∑Yes 2 □ No
9600	72 hours after death with the Maryland natural', or Items 23a or 28e-f show disal Examiner must be notified at	d by Funeral Director	10e. Street and Number  701 South Fift  11. Marital Status  1 □ Never Married 2 □ Married  3 ☑ Widowed 4 □ Divorced	12. Was Decedent Ever in U.S. Amed Forces? 1 □ Yes 2 □ No If Yes, Give Year or Dates:	10f. Zip Code  21629  13. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pu  1 □ Yes 2 ▼ No Specify:	(Specify Yes or No- erto Rican, etc.)	Citizen of What Country? nited States of America  14. Race - American Indian, Black, White, etc.  Specify: Caucasian
21215-0036	within lene. then "	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)	College (1-4or 5+)	Decedent's Usual Occupation Give kind of work done during most of w ife. DO NOT use retired) Peller	rorking 16t	Banking
Maryland	d 2 should be filed h and Mental Hygi 7 is marked other traumatic event,	To Be	17. Father's Name (First, Middle, Last)  Emmor  19a. Informant's Name/Relationship (T	Lee		ame (First, Middle, Mai White Rural Route Number, Ci	
	1 and Healt em 2		Veronica Lee  20a. Method of Disposition  1 Seurial 2 Cremation 3 D	Daughter-n 10	0480 Cordova Roa	d, Easton,	
Baltimore,	permit. Pages Department of Important: If it any njury or o		*4 Donation 5 Other (Specify,		nmount Cemetery  22. Name and Address of Facility Moore Funeral Ho	Hil	lsboro, Maryland
	Physician /Medical Examiner e prijal-itansit	Examiner	23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of Due to (or as a consequence of	t enter the mode of dying, such as carding to the second s	St., Dento ac or respiratory arrest.	on, Maryland 21629 Approximate Interval Between Onset and Death
. Box 68	death certificate e attending physid for use as the	Physician/Medical E	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 Two	d.  23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delivery Month Day Year
ords, P	The law requires that the ate has been signed by the bage 2 should be detached.	þ	Part II. Other significant conditions co	ntributing to death but not resulting in t	he underlying cause given in Part I.		co use contribute to the cause of death?
		e Completed	25. Was case referred to medical			24a. Was an autopsy performed 1 ☐ Yes 2 ☑	
ision	ding Phys h. After this funeral dii	ertification: To B	examiner?  1 Yes 2 No  27. Manner of Death 1 Watural 5 Pending investigation 2 Accident investigation 3 Suicide 6 Could not be	tospital: 1 Inpatient 2 ER/Outp  28a. Date of Injury (Month, Day Year)  28b. Place of Injury. At home, farm	atient 3 DOA Other: Nursing ne of Work?  M 1 Yes 2 No	eath (Check only one)  Home 5 Residence 28d. Describe how in	njury occurred t and Number or Rural Route Number,
=	Hospital or 4 hours afte Funeral Dir tely filled in	edical Cert	29a. Certifier 1. Certifying Phy (Check only 2 Medical Exami	ner: On the basis of examination and/	death occurred at the time, date and plate or investigation, in my opinion, death occ	City or Town, St	a(s) and manner as stated
		Med	29b. Signature and title of certifier	and manner stated.	29c. License number	29d.	Date signed (Month, Day, Year)
	35) Sta		30. Name and address of person who con Karen Moffett, 31. Date filed (Month, Day, Year)	10		Maryland 2	21629

			For Stete	State of Maryland /		nt of Health a te of Death	nd Mer	ntal Hygien Reg. N	Z11115	14331
	Physici	a n	Registrar  1. Decedent's Name (First, Middle, Last)	1   50111100			2.	Date of Death	ay Year	3. Time of Death
	/Medic	al	4a, Fecility Name (If not institution, give s	treet and number)	4b. Cit	y, Town, or Location of	Death	)4-15	c. County of Death	1431
	Examin	er	CAROUNE NURS	SING HOME	DE	NTON			CAROLI	NE
2	Funeral Director		5. Social Security Number 6. Sex	M 217 F	Yrs. If Und Month	ler 1 Year If Under 2 s Days Hours	Min. 8.	Date of Birth Month, Day, Year 1-12-19	9. Birth	place (State or Foreign
	D		Usuel Residence of Decedent  10a. State 10b. County	10c. City, To	wn or Location					10d. Inside City Limits
	Maryla 9-1 sho	ctor	MO CAROLI	NE FEDE	EXALS!	BURG				1 ☐ Yes 2 ☑ No
	with the a or 28 be rol	Direc	10e. Street and Number	2000	10f. 2	Cip Code		10g. C	itizen of What Cou	ntry?
	death	Funeral Director	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Dec	edent of Hispanic Origocify Cuban, Mexican,	in? (Specify	Yes or No-	14. Race - Ameri Black, White,	
36	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene, item 27 is marked other than "natural", or items 23s or 28e-1 show other traumatic event, the Markest Examinet manalize rollified at	by Fu	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		2₽No Specify:	1 30110 11100	, 5(5.)	Specify:	HITE
21215-0036	72 hou natura	eted	15. Decedent's Educ (Specify only highest grade	eation 16	a. Decedent's Us (Give kind of	ual Occupation work done during most use retired)	of working	16b.	Kind of Business/In	idustry
121	e filed within al Hygiene. I other then "	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	. 1	EMAKER		0	WN HO	ME
nd 2	be filed ital Hyg id other event,	Be	17. Father's Name (First, Middle, Last)	11.4			's Name (Fi	rst, Middle, Maide	n Sumame)	
Maryland	2 should be and Mental is marked o	2	19a. Informant's Name/Relationship (Typ	19 De, Print) 19	9b. Mailing Addre	ss (Street and Number	r or Rural Ro	oute Number, City	or Town, State, Zip	p Code)
	1 and 2 Health a tem 27 is		SARAH L. SHOCKLEY	DAUGHTER 2	05S.UN	IVERSITY P	VE.FE	DERALS	BURG M	021632
nore	Pages 1 nent of H nnt: If ite		20a. Method of Disposition  1 ☐ Burial 2 ☑ Cremation 3 ☐ Re  4 ☐ Donation 5 ☐ Other (Specify)	aamat	of Disposition (Nerry, crematory of		Date	20c. 1	Location - City or To	own, State DE
Baltimore,	permit. Pages Department of Importent: If i any injury or one		21. Signature of Funeral Service License	OAPI I	22. Name	and Address of Facility PAMSON FL	WERE	+L HOME		
00	90E = 9		23a. Part1. Enter the disease, or complic	eations that caused the death. Do	3115.1	nainst. F	EDAS	ACSIBURI	3 mo 21	Approximate
	Physician		shock, or heart failure. List only on Immediate Cause (Final disease or condition	e cause on each line.						Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequence	e of):					
	9.50	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequence			- 10			
	ecuted and -transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence		rkonsi	on d	2 6		· · · · · · · · · · · · · · · · · · ·
8760,	cate be executed physician and the burial-transit	dical E								
9	death certificate be execut e attending physician and nd for use as the burial-trar		IF FEMALE:	20 If yes, outcome of programmy						
Box.	death certific e attending p d for use as	Physiclan/Me	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No	3c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal deat 4 ☐ Pregnant at time of death	th 3 Ectopic 5 Other (				23d. Date of delive Month	ery Day Year
P.O.	that the death led by the atter detached for	Phys	9 Unknown  Part II, Other significant conditions continued to the significant conditions conditions continued to the significa	9 Unknown	in the underlyies	Logues gives in Part I		23e Did tobacco	use contribute to the	he cause of death?
	9 5 g	þ	nove	tributing to death but not resulting	in the discernying	cause given in Fait i.				bably 4 Unknown
ecol	aw as b	Completed						24a. Was an autopsy	24b. Were auto	opsy findings available ompletion of cause of
Vital Records,		e Con	25. Was case referred to medical			00 Bloom		perfórmed? 1 ☐ Yes 2 ☐ N	death?	2□ No
	S S D	To Be	examiner?	ospital: 1 ☐ Inpatient 2 ☐ ER/C	Outpatient 3 1	Other		5 ☐ Residence	6 ☐Other (Specif	<b>5</b> )
o uc	ding Ph h. After th funeral		27. Manner of Death  1 Natural 5 Pending investigation	28a. Date of Injury (Month, Day Year) 28b.	. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ N		Describe how inju	ury occurred	
Division of	r Attener deat rector:	Certification;	2 Accident Investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At home, building, etc. (Specify)	farm, street, facto		28f.	Location (Street a City or Town, Stat	nd Number or Rura	al Route Number,
Ö	To the Hospitel or Attending PI within 24 hours after death.  To the Funerel Director: After th completely filled in by the funera			ician: To the best of my knowledge	ge death occurre	ed at the time, date and				tated
	he Hos in 24 ho he Fun pletely	edical		er: On the basis of examination a and manner stated.						
)	To t To 1	Σ	29b. Signature and title of certifier	OM		9c. License number	55	29d. Da	ate signed (Month,	Dey, Year)
			30. Name and address of person who con	mpleted cause of death (Item 23a	(Type, Print)				, 13/0	J
			Mel-12 = Butier	3 Registrar's Signature	Ave ?	0 Box 331	, 46.	eston	WD 9.	1655
	Sta Registr		31. Date filed (Month, Day, Year) APR 1 4 2005	32. Registrar's Signature	Acces !					

			1- For State of Maryland / Dep Registrar Ce	artment of F ertificate of			giene 005	14332
A	Physici		1. Decedent's Name <i>(First, Middle, Last)</i> Myra Anne Lankford			2. Date of Dea Month April	Day Year 9, 2005	3. Time of Death 1215 M
	/Medio Examir		4a. Facility Name (If not institution, give street and number)  Caroline Nursing Home	4b. City, Town, o	1	Death	4c. County of Dea	ine
	Funeral Director		5. Social Security Number  222-50-8412  6. Sex 1 M 27 F 7. Age (In yrs. last birthday, 68 Yrs.	Months Days		Min. 8. Date of Birth (Month, Day Oct. 1.	9. 8i 3, 1936 M	nthplace (State or Foreign country) aryland
	e Maryland Ba-f show	Director	10a. State 10b. County 10c. City, Town or L Caroline	Denton				10d, Inside City Limits 1
	h with th	al Dire	10e. Street and Number 520 Kerr Avenue	10f. Zip Code	21629		10g. Citizen of What C United S	,
36	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other then "natural", or Items 23s or 28s-f show aumatic event, the Medical Exam is an initial be notified at	by Funeral	11. Marital Status  1 X Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 Yes 2 No If Yes, Give Year or Dates:	Was Decedent of HIFYes, specify Cub		n? (Specify Yes or No- Puerto Rican, etc.)	14. Race - Am Black, Wh Specify:	
Maryland 21215-0036	within 72 hou and. then natural	Completed	(Specify only highest grade completed) (Give	edent's Usual Occup e kind of work done DO NOT use retire N/A	during most	of working	16b. Kind of Busines:	
land 2	i Hygi other	To Be Co	17. Father's Name (First, Middle, Last) Scott Lankford, Sr.			's Name (First, Middle, M. Brins	Maiden Sumame)	
Man	od 2 sho					Blvd., Se		
altimore,	permit. Peges 1 and 2 should be Department of Health and Menta important: If item 27 is marked any injury or other traumatic angone.		20a. Method of Disposition  The Burial 2 Cremation 3 Removal from State  4 Donation 5 Other (Specify)	osition (Name of amatory or other pla	ery 0	Date 4/12/05	Near Federals	t Town, State
Balti	permit. Departn imports any inju		21. Signature of Funeral Service Licensee  Michael T. Eskew- 2	2. Name and Addre	ess of Facility In St.,	Framptom Federalsb	Funeral urg, MD 21	Home, P.A 632
3760,	te be executed hysician and hysician and hysician and hysician sit in the buriat-fransit	Ilcal Examiner	23a. Part1. Enter the disease, or complications that caused the death. Do not er shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, interest of this by that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):	[a				Interval Between Onset and Death
.O. Box 6	w requires that the death certificat been signed by the attending phy should be detached for use as th	Physician/Med		□Ectopic pregnanc □ Other (specify) _	у		23d. Date of de Month	Blivery Day Year
0	quires that I n signed by uld be deta	by	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause gr	ven in Part I.	23e. Did to	bacco use contribute i	to the cause of death?  Probably 4 Unknown
Il Records,	2 5 6	Completed	DOWNES SYNDERO	Me		24a. Was a autop: perfor 1 Yes	sy prior to	autopsy findings available completion of cause of s 2 No
Vita	rsician: Th s certificate director, pag	To Be	25. Was case referred to medical examiner?  1  Yes 2 10 0 Hospital: 1 Inpatient 2 ER/Outpatie	ent 3 DOA	her /	of Death (Check only or sing Home 5 Resid		ecify)
Division of Vital	To the Hospitel or Attending Physician: The I within 24 hours after death. To the Funerel Director: After this certificate ha completely filled in by the funeral director, page		27. Manner of Death 1	of 28c. Inju		28d. Describe h	ow injury occurred	
Divis	To the Hospitel or Attending I within 24 hours after death.  To the Funerel Director: After completely filled in by the funer	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	treet, factory, office		28f. Location (S City or Tow	treet and Number or F n, State)	Rural Route Number,
	To the Hospitel or within 24 hours after To the Funerel Dirt completely filled in I	edical	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, deal call Exeminer: On the basis of examination and/or in and manner stated.	th occurred at the ti nvestigation, in my	ime, date and opinion, death	place, and due to the on occurred at the time, o	ause(s) and manner a late and place, and du	s stated. e to the cause(s)
)	To the To the comp	W	29b. Signatur and title of certifier	29c. Licen	se number	76	29d. Date signed (Mon	ith, Day, Year)
			30. Name and address of person who completed cause of death (Item 23a) (Type	applet	_ <	st Dei	tou	10
	Sta Regist		31. Date filed (Month, Day, Year)  APR 1 2 2005  32. Regisfrar's Signature	Sarte				

			1 – For State Registrar	State	of Marylar		artment of tificate of			lental Hyg	iene	5	4333	
	Dhuniai	<b>an</b>	1. Decedent's Name (First, Middle, Last	)						2. Date of Deat Month		Year	3. Time of Death	
	Physici /Medio		HEWISSE PAUL LAS							APRIL		2005	12:35P	M
	Examin	er	4a. Facility Name (If not institution, give		imber)		4b. City, Town,				4c. County			
			HOLY CROSS HOSP I  5. Social Security Number 6. Se		7. Age (In yrs.	last hirthday	SII If Under 1 Yea	VER S	SPRINO or 24 Hrs.	3 8. Date of Birth	MOI	VTGOM		
	Funeral Director		227 26 6109 XX	1 M 2□F	7. Age (III yrs.	80 Yrs.	Months Days			(Month, Day,	, 1925	9. Birthp Coun	lace (State or Foreitry) TU CADOLT	gn N
			Usual Residence of Decedent		1	00				MAR. 21	, 1923	NOK	TH CAROLI	INZ
	yland		10a. State 10b. County		10c. Ci	ty, Town or Lo	cation					1	0d. Inside City Limi	
	B Ma	Director	DC		V	ASHING	TON						XXYes 2□N	0
	if th	Olre	10e. Street and Number				10f. Zip Code			1	0g. Citizen of V	Vhat Coun	try?	
	23a	ra	900 G STREET, NO	-				20002			UNITE			
	be filed within 72 hours after death with the Maryland tal Hygiene. Id other than "natural", or items 23a or 28a-f show odher than "natural", or items 23a or 28a-f show event, the Medical Examinar must be multiled at	Funeral	11. Marital Status	Armed F	edent Ever in U		Vas Decedent of Yes, specify Cu	Hispanic C ban, Mexic	rigin? (Spe an, Puerto	ecify Yes or No- Rican, etc.)		e - Americ k, White,		
36	rs aft	by F	1 Never Married 2 Married 3 Married 3	If Yes G	2 □ No11 <b>-</b> ive Dates: 4 <b>-</b> 12		Yes ZXN	Specify	y:		Specify	BLA	CK	
215-0036	2 hou	ed	15. Decedent's Edu		74.00. 4 12	16a. Deced	lent's Usual Occi	pation			16b. Kind of Bu	siness/Inc	dustry	
212	nn 77	Completed	(Specify only highest grad		(1-4or 5+)	(Give	kind of work don DO NOT use retir	a dunna mo	ost of worki	ng			,	
2	d with	ĕ	10TH	College	(1-401 54)	C.	AB DRIVE	R			PRI	VATE		
פ	m - 0 %	Be C	17. Father's Name (First, Middle, Last)					18. Mot	her's Name	(First, Middle, A	laiden Sumam	Θ)		
Maryland	should be nd Mental marked o	70	PAUL LASSITER					LU	ICY RO	SE				
a	and and sm		19a. Informant's Name/Relationship (T)				_			il Route Number,			Code)	
	1 and 2 Health Iem 27 i		CALVIN LASSITER	/ SON	201-1		KEITH S	T.		E HILLS				
0			20a. Method of Disposition  XXBurial 2 □ Cremation 3 □ I	Removal from		cemetery, cren	sition (Name of natory or other pl	ace)		ate	20c. Location -	City or To	wn, State	
	tmen tant: jury		4 □Donation 5 □Other (Specify,		CE		LL CEMET			2005	SUITI			
Baltimore,	permit. Page Department Important: fi any injury o		21. Sign tute of Fugeral Service Licens	Lei	2	M 4	ARSHALL 308 SUIT	S FUN LAND	ERAL ROAD	HOME OF	MARYLA LAND, M	ND, II D 20	NC. 746	
	Pnysician /Medical Examiner		23a. Part / Enter the disease, or comp should be compared to the composition of the compo	aANOX	caused the deal each line. CIC ENCE (or as a consec	PHALOP		ing, such a	s cardiac c	r respiratory arre	st,		Approximate Interval Between Onset and Death	
8/60,	cate be executed physician and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to	(or as a consec									
O. Box 6	requires that the death certifica een signed by the attending ph hould be detached for use as th	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 Live i	atcome of pregnations of control	Il death 3	Ectopic pregnand Other (specify)	су			23d. Dat Mor	e of delive	ry Day Year	
S, T	s that ned b e deta	by PI	Part II. Other significant conditions co	ntributing to d	ieath but not res	sulting in the ur	iderlying cause g	iven in Part	L	23e. Did tob	acco use contr	ibute to the	e cause of death?	
ğ	w require been sig should by		SEIZURES, UROSEPS	IS, DI	ABETES,	PROSTA	ATE CANC	ER, G	OUT	1 □ Ye	s 2 🗆 No	3 🗌 Proba	ably 4XXInknow	n
II Kecord	The law ate has b page 2 si	Completed								24a. Was ar autopsy perform 1 Yes 2	ed?	Vere autoprior to com eath?	sy findings availab apletion of cause of 2 \( \square\) No	9
VITAI	ysician: Th is certificate director, pag	Be	25. Was case referred to medical examiner?	lospital: 37.55					e of Death	(Check only one	)			
0	d is y	- To	1 ☐ Yes XXNo  27. Manner of Death	28a. Date		ER/Outpatien 28b. Time of	28c. Inju			ne 5 Reside			)	
	ding Ph h. After th funeral	ton	XXNatural 5 Pending	(Mon	nth, Day Year)	Injury	W	ork? Yes 2		ad. Describe no	w injuly occurr	30		
DIVISION	Hospitel or Attending     La hours after death.     Funerel Director: After etely filled in by the funerel	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place build	e of Injury - At h ling, etc. (Specil	ome, farm, stre (y)	eet, factory, office		_	28f. Location (Str. City or Town,	eet and Numbe State)	er or Rural	Route Number,	
	To the Hospitei within 24 hours a To the Funerei C completely filled	edical	29a. Certifier (Check only one)  Check only 2 Medical Exami	ner: On the b	e best of my kno pasis of examina iner stated.	owledge, death ation and/or inv	occurred at the testigation, in my	ime, date a opinion, de	ath occurre	and due to the ca ed at the time, da	use(s) and ma te and place, a	nner as sta ind due to	ated. the cause(s)	
	To the within 2: To the complet	Σ	29b. Signature and little of certifier		0		29c. Licen	se number		29	d. Date signed	(Month, E	Day, Year)	
	011		> XMue	erall	wooder	Un M-	0 00	005	76:	30	APRIL	12, 2	.005	
	4) 1/2		30. Name and address of person who ca	ompleted cau	se of death (Iter	п 23а) (Туре, Т	•							_
	0 104		ANURADHA ARUN, M.		Decision de Ci		10301 G	EORGI.	A AVE	. SILV	ER SPR	ING,	MD 20902	
	Sta Registr		31. Date filed (Month, Day, Year)  APR 1 4 2005	Ke	Registrar's Signa	aturo.	Ri							

			1 - For Stata Registrar	State of Mary		partment of I		, ,	iene	
	Physici		Decedent's Name (First, Middle, Last)     CHARLES	MCLANE				2. Date of Deat Month APRIL		3. Time of Death 1
	/Medio Examin		4a. Facility Name (If not institution, give FREDERICK MEMO)	street and number)	ral	4b. City, Town,	or Location of Dea		4c. County of I	Death
	Funeral Director		214-10-0030		yrs. last birthda 4 Yrs.	Months Days			Year) 9. 1920 B1	Birthplace (State or Foreign Country) cunswick MD
	Maryland f ehow	tor	Usual Residence of Decedent           10a. State         10b. County           MD         Frederic		Brunsw					10d. Inside City Limits 1X∑Yes 2 ☐ No
	with the	Director	10e. Street and Number 609 West Potomac S	treet		10f. Zip Code 217	16	1	0g. Citizen of Wha	t Country?
036	be filed within 72 hours efter death with the Maryland at Hygiene. All Hygiene. do ther than "naturel", or items 23s or 28s-f show avent, the Medical Examinar must be notified at	by Funeral		12. Was Decedent Ever Armed Forces? 1 X Yes 2 ☐ No If Yes, Give	in U.S. 13	. Was Decedent of If Yes, specify Cub		Specify Yes or No- rto Rican, etc.)	Black, \	America <i>n</i> Indian, White, etc. <b>White</b>
21215-0036	vithin 72 ne. han "na!	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12) 1 2		(Giv	edent's Usual Occu re kind of work done DO NOT use retire Special	during most of word)	orking	State of	ess/industry Maryland
73		To Be C	17. Father's Name (First, Middle, Last)  David William McLa	ne			Margare	ame (First, Middle, A t Elizabe	th Donov	
	7		19a. Informant's Name/Relationship (Ty Margaret L. Griffi					Rural Route Number, reet, Brun		
altimore,	Pages ent of nt: if t		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ F 1 ☐ Donation 5 ☐ Other (Specify)	emoval from State	cemetery, cr	position (Name of ematory or other pla own Cremat			20c. Location - City Lagerstow	
Balt	permit. I Depertm Importal any inju		21. Signatur 1 Jung / Serice Con- Barbara A. Will	iams, Owner	. 1		illiams	Funeral H		D 21716
	Physician / Medical by Second of the prijal-transit physician and physician and physician are physician and physician are physician and physician are physician and physician are physician and physician are physic	dicai Examiner	23a. Part1. Enter the disease, or comply shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	e cause on each line.	nsequence of):	nter the mode or dy	ng, such as cardia	ac or respiratory arre	ISI,	Approximate Interval Between Onset and Death
.O. Box 68	ath certifi ttending	by Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pr 1 □ Live birth 2 □ 4 □ Pregnant at time 9 □ Unknown	Fetal death 3	□Ectopic pregnand □ Other (specify)	у		23d. Date of Month	delivery Day Year
<u>a</u>	w requires that the de been signed by the a should be detached t	ed by Pt	Part II. Other significant conditions con	etributing to death but no		underlying cause gr	ven in Part I.	23e. Did tob		te to the cause of death?
I Records,		Completed	chologists					24a. Was ar autops perform 1 Yes 2	prior deat	e autopsy findings available to completion of cause of h? Yes 2 \sum No
Vital	sicien: certific rector,	Be	25. Was case referred to medical examiner?	ospital:		Ot	hac	eath (Check only one		
Division of	To the Hospitel or Attending Physicien: within 24 hours after death of the Funerel Director. After this certifical completely filled in by the funeral director,	ation: To	1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Yea	2 ER/Outpati 28b. Time Injury	of 28c. Inju	ry at	Home 5 Reside 28d. Describe ho		Specify)
Divis	tel or Atters after des el Director ed in by the	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc. (S)	At home, farm, soecily)	street, factory, office		28f. Location (Str City or Town		r Rural Route Number,
	ne Hospi ne Funer betely fill	edical	29a. Certifier 1 ☐ Certifying Physical (Check only one) 1 ☐ Certifying Physical Examination (Check only one)	sician: To the best of my ner: On the basis of exa- and manner stated.	knowledge, dea mination and/or	ath occurred at the ti investigation, in my	me, date and place opinion, death occ	ce, and due to the ca curred at the time, da	use(s) and manne te and place, and	r as stated. due to the cause(s)
	To the Comp	X	29b. Signature and title of certifier	elan it		29c. Licen.		29	d. Date signed (M	fonth, Day, Year)
	×		30. Name and address of person who co	mpleted cause of death	(Item 23a) (Type		08890		4/10/02	
,	9		Caroline Gerser	4 ma 610	9th A		Fransw.	am 1/2	21716	
	Sta Registr		31. Date filed (Month, Day, Year) 4 2	005 32. Registrar's S	Signature	Small !				

			State of Maryland / Department of Health  1- State Registrar Certificate of Death			iene <sub>eg. <b>N</b>o. () (</sub>	)5	14335
	Physic	ian	1. Decedent's Name (First, Middle, Last)		2. Date of Deat		Year	3. Time of Death
	/Medi	cal	Virginia I. Matthews		4	14	2005	0910 HN
	Examir	ner	4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location  SAII  SAII	skill	<b>/</b>	1	y of Death	11Co
	Funeral Director		215-18-4730 1 M 2 F 98 Yrs. Months Days Hours	Min.	B. Date of Birth (Month, Day, 8-1-190	Year)	9. Birthp Coun V	place (State or Foreig htry) A •
	land ow		Usual Residence of Decedent         10a. State         10b. County         10c. City, Town or Location			-	1	0d. Inside City Limits
	Mary a-f eh	tor	Md. Worcester Snow Hill					1X Yes 2 □ No
	or 284	Director	10e. Street and Number 10f. Zip Code		1	0g. Citizen of	What Coun	itry?
	s 23e		266 S. Washington St. Apt. 106 21863			USA		
10	rurs after death with the Manylan el', or Items 23e or 28e-f ehow Examiner aust be nattied at	Funeral	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forceş?  1 □ Never Married 2 □ Married  12. Was Decedent of Hispanic O. If Yes, specify Cuban, Mexica	rigin? (Spec an, Puerto Ri	ify Yes or No- ican, etc.)		ce - Americ ick, White,	
21215-0036		by	If Yes, Give 1 ☐ Yes 2 No Specify Year or Dates:	<i>/</i> :		Specia	<sup>ty:</sup> Whi	te
5-0	"netu	Completed	15. Decedent's Education (Specify only highest grade completed)  [Second of the completed]  [Second of the completed]  [Second of the completed]  [Second of the completed]  [Second of the completed]  [Second of the completed]	st of working	,	16b. Kind of E	Business/Ind	dustry
12	withir ene. then	dwc	Elementary/Secondary (0-12) College (1-4or 5+)  10 Poultry Grower			Poult	rv	
þ.	be filed within 72 ho tal Hygiene. of other then "netu event, Ire Madical	0		ner's Name (	First, Middle, M			
Maryland	nd 2 should be filed within and Mental Hygiene. 27 is marked other then " r treumetic event, It e Max	To B			ns Maso			
Mar	12 sh h and 7 is m treum		19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Numb					
	a 90 E 5		Frances Selby, Sister 802 College Lane  20a. Method of Disposition 20b. Place of Disposition (Name of	Apt.		20c. Location		
OE I	Pages lent of nt: If i		1X☐ Burial 2 ☐ Cremation 3 ☐ Removal from State  `4☐ Donation 5 ☐ Other (Specify)  Trinity Garden Of	4-17-0		Newar		d.
Baltimore,	pernit. Pages 1 Department of H Importent: If ite any injury or ott		21. Signature of Funeral Service Licensee  22. Name and Address of Facil  Short Funeral	lity			,	
	20 E 29	9 1	13 E. Grove S	t. De	lmar, D	e. 199	40	
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as shock, or heart ailure. List only one cause on each line.	s cardiac or	respiratory arre	est,		Approximate Interval Between Onset and Death
1	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)  a. LONGESTIVE IMPAST FA	12 UB	K			YRS
0	Examiner		Due to (or as a consequence of):					¥41
315-18-4730	70 ##	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury					F 20.
18	ecute and I-trans	Examiner	Cause (Disease or injury that initiated events c. resulting in death) Last Due to (or as a consequence of);					
315-1	icate be executed physician and the burial-transit	dlcal E	Due to (or as a consequence of).					
89			0.					
SOX	death certific e attending p id for use as f	an/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 mogths?  23c. If yes, outcome of pregnancy 1				te of delive	•
O.	0 0 0	by Physiclan/Me	1 ☐ Yes 2 ☐ Mo 4 ☐ Pregnant at time of death 5 ☐ Other (specify)			Mic	onth	Day Year
1 h	The law requires that the site has been signed by the bage 2 should be detache	y Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part	I.	23e. Did tob	acco use con	ribute to the	e cause of death?
Q 7	w requires I been signe should be				1 □ Ye	s 2 <b>D</b> No	3 Proba	ably 4 □Unknown
Reco	e taw re has be ge 2 sho	Completed			24a. Was an	24b.	Were autop	osy findings available
al R					perform	red?	death? 1 🗌 Yes	· ·
2/Q Vital		o Be	examiner?		Check only one			
311	g Phys er this ieral di	n; To	27. Manne of Death 28a. Date of Injury 28b. Time of 28c. Injury at		5 Resident			)
Sior	Attending For death.  ector: After by the funer.	atlo	1 ☐ Natural 5 ☐ Pending (Month, Day Year) Injury Work? 2 ☐ Accident investigation M 1 ☐ Yes 2 ☐	]No				
Divisio	or Att	Certification:	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28	f. Location (Str. City or Town,	eet and Numb State)	er or Rural	Route Number,
	To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral		29a. Certifier  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date an (Check only 2 Medical Examiner: On the basis of examination and/or investigation in my opinion death.	nd place, and	d due to the ca	use(s) and ma	inner as sta	ated.
	the H hin 24 the F nplete	Medical	one) and manner stated.	ain occurred				
	To To	-	29b. Signature and title of certifier  29c. License number	0	29	d. Date signe	d (Month, E	ay, Year)
	00		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	7		1-/	7-0	0
	29		D. A. Chodnicki, m.D. 400 E shore Dr.	54	Misbun	y N	20	
	Sta Registr		31. Date Med (Month, Day, Year)  APR 1 5 2005  September 1 5 2005		/			

			1 - For Stata Registrar	State of Mary		artment of <i>rtificate of</i>		ind Mental Hy	giene	11115	14336
			1. Decedent's Name (First, Middle, Las	)				2. Date of D Month			3. Time of Death
	Physici /Medic		Roy Morga	ın				April	10,	2005	4:15P M
?	Examin	er	4a. Facility Name (If not institution, give			4b. City, Town,		f Death		County of Death	
			Southern Maryland  5. Social Security Number 6. Se		yrs. last birthday)	Clintor		24 Hrs. 8. Date of B		ince Geo	
	Funeral Director				8 Yrs.	Months Days		Min. (Month, D	ay, Year)	Cour	place (State or Foreign ntry) h Carolina
	D.		Usual Residence of Decedent					Aug. 2	-7 g I		ra Maria
	show	-	10a. State 10b. County		c. City, Town or Lo					1	10d. Inside City Limits  1X☐ Yes 2 ☐ No
	28e-1	Director	Maryland   Prince G	eorge UI	oper Mar	1			10- 00		
	d within 72 hours after death with the Maryland jiene. r than "netural", or items 23a or 28e-f show the Madical Examiner mutt be natified at		3510 Eyre Drive S	South		10f. Zip Code	207	72	_	ed State	
	ms 23	Funerai	11. Marital Status	12. Was Decedent Ever	in U.S. 13.	Was Decedent of		gin? (Specify Yes or N , Puerto Rican, etc.)		14. Race - Americ	
9	or iter	Fur	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☑ No		_		Puerto Rican, etc.)		Black, White,	
933	ral,	d by	3 ☑ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2/21/No	Specify:			Specify: B1	ack
15-(	"net	Completed	15. Decedent's Edi (Specify only highest grad	ucation le completed)	16a. Dece (Give	dent's Usual Occu kind of work done DO NOT use retin	pation during most	of working	16b. Ki	nd of Business/In	dustry
12	within ene. than "	ш	Elementary/Secondary (0-12) 3rd	College (1-4or 5+)		struction			Con	structio	n
9	il Hygi other	Be Co	17. Father's Name (First, Middle, Last)					's Name (First, Middle			
lan	Aental Aental rked c	To B	Unknown				Unk	nown			
Maryland 21215-0036	ges 1 and 2 should be filed t of Health and Mental Hyg If item 27 le marked othe or other treumatic event,		19a. Informant's Name/Relationship (T	ype, Print)	19b. Maili	ng Address (Stree	t and Number	r or Rural Route Numi	ber, City o	r Town, State, Zip	Code)
	and 2 lealth m 27 in		Annie Robinson/I					th; Upper			
Baltimore,	ges 1 art of Heal		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	Removal from State	Ob. Place of Dispo cemetery, cre	osition (Name of matory or other pla	ace)	Date	20c. Lo	cation - City or To	own, State
ij	permil. Pages i Department of H Importent: If ite any injury or ot once.		* 4 □ Donation 5 □ Other (Specify,		4 / /			oril 16, 2005			D.
Bal	Depar Depar Impor any ir		21. Signature of Funeral Strice Licens	1/5/		2. Name and Addr	ess of Facility	TOPC TUI	eral	Homes o Pike	
			23a. Part 1. Enter the disease of comp shock, or heart failure. List only of	lications that caused the	death. Do not en	ter the mode of dv	ing such as c	Forestvi	IIe,	o Pike MD. 20	747 Approximate
			shock, or heart failure. List only of Immediate Cause (Final	ne cause on each line.			_ ^		- 4	,	Interval Between Onset and Death
	Pnysician /Medical		disease or condition resulting in death)	a Due to (or as a cor	nsequence of):	tule	-P	e 0 101-6	222	(cye	
r.	Examiner			L -=		Ama	· Pa	13 3	u		
	D ==	ner	Sequentially list conditions, 1 any, leaving to funded cause. Enter Underlying Cause (Disease or injury	Dua to (or as a nor	rsaquence of):	0 0	(				
	ecuter ind trans	Examin	Cause (Disease or injury that initiated events resulting in death) Last	с		100010	8				
8760,	cate be executed physician and the burial-transit		resulting in ocultify East	Due to (or as a cor	nsequence or):	Q-	o hic	quod	PC		
687	physics the	dicai		d				0,00			
Box (	the death certificate be executed y the attending physician and iched for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pr					2	23d. Date of delive	ery
	death e atte	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live birth 2 ☐ 4 Pregnant at time		⊒Ectopic pregnand ☐ Other (specify) _				Month	Day Year
P.0	that the de ed by the detached	hys	9 Unknown	9□ Unknown							
	es De de	by	Part II. Other significant conditions co	ntributing to death but no	t resulting in the u	inderlying cause g	ven in Part I.				ne cause of death?
Vital Records,	w requir	ompieted	1455	YU CE	<del>     </del>				Yes 2[	□No 3□Prob	ably 4 Dhknown
Sec	has b	npie	Volutor	1 4 68	(on			24a. Was		24b. Were auto prior to coo death?	psy findings available mpletion of cause of
a	Th ate pag	O	- CA (	Colone	allen	Mleo	cut t	V Secrit Yes	2 <b>V</b> No		2 No
ΖÏ		o Be	25. Was case referred to medical examiner?  1  Yes 2 No	Hospital:	2 ER/Outpatie	at 2/1004 Of	her	of <b>p</b> eath (Check only sing Home 5 ☐ Res		COther (Specif	
of		-	27. Manner of Death	28a. Date of Injury	28b. Time o	f 28c. inju	ıry at	28d. Describe			7)
ion	Attending Ph r death. ector: After th by the funeral	atio	1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Yea	ar) Injury		ork? ]Yes 2.⊟N	io			
Division	I or Attenation after death	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - building, etc. (St	At home, farm, st	reet, factory, office			(Street and	d Number or Rura )	I Route Number,
	Itel or A	Cer									
	To the Hospitel or At within 24 hours after or To the Funerel Direct completely filled in by	Medical	(Check only 2 Medical Exam	rsician: To the best of my iner: On the basis of exam	rknowledge, deat mination and/or in	h occurred at the to exestigation, in my	ime, date and opinion, death	I place, and due to the h occurred at the time	cause(s) , date and	and manner as si place, and due to	tated. the cause(s)
	To the within 2 To the complet	Med	29b. Signature and title of certifier	and manner stated.		29c. Licer	se number	-	29d. Dat	e signed (Month,	Day, Year)
	To		) Grant	1 9112	end of			8	1	f. (0.	2001-
)	(5)		30. Name and address of person who o	ompleted cause of death	(Item 23a) (Type)	00	26 U	odya	ed	000	7 11
	0		ABULH ASAA	ANSM	1	0(8	n-fan	Mat.	20	23(	-4 (0)
	Sta		31. Date filed (Month, Day, Year)  APR 1 4 2005	2. Registrar's S	Signature	. ·					
	Registr	ar	APR 1 4 2005	place ,	# Apo						

			Please T				Ink. Ensure	•	_	e.
			1 - For State Registrar	State of Mar	•	•	of Health and of Death		jiene eg. No.?	E 11007
	Physici /Medio		1. Decedent's Name (First, Middle, Last) SYLVESTER	J.		FEE, J		2. Date of Dea Month	The state of the s	3. Time of Death 3. 08P M
	Examir		4a. Facility Name (If not institution, give s		ITAL		own, or Location of Dea $NHAM$			Death CEORGES
	Funeral Director		5. Social Security Number 577-82-1848 6. Sex 115 Usual Residence of Decedent	7. Age (	In yrs. last birthd 42 Yrs	Months	Year If Under 24 Hrs Days Hours Min		1962 W.	Birthplace (State or Foreign Country) ASH., DC
	Maryland f show	tor	10a. State 10b. County  MD P. G.	1	Oc. City, Town o	r Location	F			10d. Inside City Limits 1, Yes 2 □ No
	28a	rec	10e. Street and Number		11110111	10f. Zip C		1	l0g. Citizen of Wha	A
	h with		3305 SAVILLE I	LANE			20721		U.S.A	
36	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene, itam 27 is marked other than "natural", or items 23e or 28e-f show other traumetic avant, the Modical Examinating the inclined at	by Funeral Director	11. Marital Status 1 □ Never Married 2 🏋 Married	I2. Was Decedent Ev Armed Forces? 1 ☐ Yes 2 No If Yes, Give	er in U.S. 1		nt of Hispanic Origin? (in Cuban, Mexican, Pue	Specify Yes or No- rto Rican, etc.)	14. Race - A Black, V	American Indian, Vhite, etc.
Ş	hours tural',		3 Widowed 4 Divorced	Year or Dates:	160 Do	ecedent's Usual				BLACK
5	n na	plet	(Specify only highest grade	completed)	(G	ive kind of work o. DO NOT use	done during most of wo	orking	16b. Kind of Busin	ess/industry
212	giene. er than	Completed	Elementary/Secondary (0-12) 12th	College (1-4or 5+)		DGE ME	CHANIC		D.C. GO	VERNMENT
Maryland 21215-0036	2 should be filed within 7 and Mental Hygiene. 7 is marked other than 7 reumetic avent, Ibe Mod	Be	17. Father's Name (First, Middle, Last)					me (First, Middle,		
<u>Ş</u>	d Men narka netic	ပ	SYLVESTER  19a. Informant's Name/Relationship (Type		NEFEE,		QUEEN			
Ma	l and 2 si lealth an im 27 is r iher traur		TANYA MENEFEE				ILLE LANE			
re,	s 1 ar of Hea itam other		20a. Method of Disposition		20b. Place of Di	sposition (Name crematory or other	of er place)	Date	20c. Location - City	or Town, State
imo	Page nent c ant: If ury or		1 ☐ Burial 2 ☐ Cremation 3 ☐ R.  4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	LINCOLN	MEM.	CEM. 4-	16-05		
Baltimore,	permit. Pages. Department of H Important: If its any Injury or of		21. Signature of Funeral Service Sicense	00			Address of Facility T			
	40=40	_	23a Part 1 Enter the disease or compli	cations that caused th	e death. Do not					H.DC 20001 Approximate
	Physician /Medical		23a. Part1. Enter the disease, or complishock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	Pulmona		olism				Interval Between Onset and Death
ŀ	Examiner	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Disease or in jury that initiated events	Due to (or as a c	consequence of):					
60,	executed in and ial-transi	Examiner	that initiated events cresulting in death) Last	Due to (or as a c	consequence of);					
6876	certificate be nding physicia use as the buri	dlcal	d							
.O. Box (	atter for u	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of 1□Live birth 2   4□Pregnant at tin 9□Unknown	Fetal death	3 □Ectopic preg 5 □ Other (spec			23d. Date of Month	delivery Day Year
Д.	w requires that the de been signed by the should be detached	d by Ph	Part II. Other significant conditions con	tributing to death but	not resulting in th	e underlying cau	se given in Part I.		_	e to the cause of death?  Probably 4 [Nunknown
I Records,	The la te has	Completed						24a. Was a autops perforr 1 Yes	y prior	e autopsy findings available to completion of cause of h? Yes 2 \sum No
/ita	lcian: Th certificate rector, pag	Be	25. Was case referred to medical examiner?					ath (Check only on	e)	
of Vital	iding Physician: th. : After this certifica s funeral director, p	2	1 ☐ Yes 2 ☐ No	ospital:		tient 3 DOA		Home 5 Reside	ence 6 Other (S	Specify)
O	Attending r death. actor: After	tlon	1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Y	(ea <i>r</i> ) Injui	ry M	linjury at Work? 1 ☐ Yes 2 ☐ No	200. 0 00000 1.0	on injury occurred	
Division	To the Hospitel or Attendii within 24 hours after death. To the Funeral Diractor; A completely filled in by the fu	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc.	- At home, farm, (Specify)	street, factory, o	office	28f. Location (St City or Town		r Rural Route Number,
	na Hospit n 24 hour na Funera letely fille	edical (	29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Examin	sician: To the best of a ner: On the basis of ex and manner state	camination and/o	eath occurred at r investigation, in	the time, date and place my opinion, death occ	e, and due to the courred at the time, do	ause(s) and manne ate and place, and	r as stated. due to the cause(s)
5	To th withir To th comp	Me	29b. Signature and title of certifier	O'BAio	4 A A I		icense number	2	9d. Date signed (M	onth, Day, Year)

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)
APR 1 4 2005

2. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print).

Sharon O'Brien, M.D. - 3800 Resevoir Road, NW Washington, DC

20007

				For State Registrar		State o	f Maryl	and / [	Departm <i>Certific</i>				Mental Hy	giene	005	143	38
				Decedent's Name	(First, Middle,	Last)							2. Date of De			3. Time of I	Death
		Physici		Leslie	_	ames	Merr	·i++					Month	OP Day	2005		М
	À	/Medic		4a. Facility Name (If I				100	4b	City, Town, o	r Location	of Death			County of Dea	1475	
		Examin	ier -	Peninsula	1-0:	200/200	1:/	Ca - 6		5.1	-6.	/			11:12	vi.	
		Cupaval		5. Social Security Nu	mber 9 6	Sex	7. Age (In)	rs. last bir	thday) If U	nder 1 Year	If Unde	24 Hrs.	8. Date of Bi	rth /	9. Bir	tholace (State or	Foreign
		Funeral Director		213-22-73		1 <b>X</b> M 2□F	77		Yrs. Mon	ths Days	Hours	Min.	12/1/1	a <i>y</i> , Ye <i>ar)</i>		thplace (State or ountry) 'yland	. or orgin
				Usual Residence of D									12/1/1	721	l'idi.	yrand	
		yland		10a. State	10b. County		10c.	City, Tow	n or Location							10d. Inside City	y Limits
		Mar Mar	ţō	Maryland	Wicon	mico		Sal	sbury							1 X Yes	2 🗌 No
		r 288	Director	10e. Street and Numl	ber				10	. Zip Code		-		10g. Citiz	zen of What C	ountry?	
		or death with the Marylar tems 23a or 28a-f show ar Itust Le rediffed at		508 Buer	na Vista	a Ave.				2180	4			U	SA		
		death ms 2	Funeral	11. Marital Status		12. Was Dece		n U.S.	13. Was D	ecedent of H	lispanic C	origin? (Sp	ecify Yes or No Rican, etc.)	0- 1	4. Race - Am		
	9	after or Ite	Ē	1 Never Marrie	d 2 Marrie	Armed Fo	2 □ No						Hican, etc.)		Black, Whi	te, etc.	
	g	al', c	by	3 DWidowed 4	Divorced	Year or D	e Army	,	1 1	es 2. INO	Specif	y:			Specify:	white	
	21215-0036	72 hc	ted	/Specif	15. Decedent's	Education grade completed)		16a.	Decedent's	Usual Occup	ation	net of words	rina	16b. Kir	nd of Business	/Industry	
	21	thin .	gu	Elementary/Second		College (1	-4or 5+)	_	life. DO NO	T use retired	d)	351 OI WOIN	g	_			
	2	filed within 72 hours after death with the Maryland Hygiene. uther than "natural", or tlems 23a or 28a-f show ant, I'm Medical Exar, in writinal be incilited at	Completed	12				Sa	ales					Del	aware '	Tire Co.	
	P	be filed ital Hygi d other evant, I	Be (	17. Father's Name (F		*	LL					_	e (First, Middle		Sumame)		
Λ .	/a	Ment Ment	2	George W	vasning	ton Merri	LTT				V10	та Ма	e Pruit	ככ			
12	Maryland	s 1 and 2 should be fi f Health and Mental F ttam 27 is marked ot other traumatic evan	1 18	19a. Informant's Nan	ne/Relationship	(Type, Print)		19b	. Mailing Add	ress (Street	and Num	ber or Run	al Route Numb	er, City or	Town, State,	Zip Code)	
3		1 and 2 : Health ar am 27 is		Ruth J. M	Merritt,	/wife			508 Bu	ena Vi	sta		Salish	oury,	MD 218	304	
	ore			20a. Method of Dispo		□Removal from	C1-1-	cemeter	Disposition y, crematory	or other place	ce)		Date	20c. Loc	cation - City or	Town, State	
1	Ĕ	Pages nent of I int: If its iry or o		`4 □ Donation 5	Cremation 3 MOther (Spe	©itanovai irom ©itantombra	nt W	icomi	ico Mei	morial		4/14	1/2005	Sal	isbury	, MD	
8	Baltimore,	permit. Page Department of Important: If any injury or once.		21. Signature of Fun	eral Service Lik	ensee				e and Addre	ss of Fac					Associat	
4/18/05	m	permi Depa Impo any ir once		Day	W/h	Med							Salish				.10n
7	1	1 5 5 5		23 Part Enter the shock, or heart	disease, or co	omplications that	aused the d	leath. Do							100 211	Approximate Interval Betw	
		Physician		Immediate Cause (F	inal	_	1			200						Onset and D	eath
U		/Medical		disease or condition resulting in death)		aDue to	or as a of	sequence	fory of):	Tailu	RE						
• 1	Е	Examiner					ARD		0)								
0	3		ē	Sequentially list condificant, leading to immorause. Enter Under Cause (Disease or in	ditions, nediate	0.	or as a con		of):								
20		be executed ician and burial-transit	Examiner	Cause (Disease or in that initiated events	njury	C	VIRA	-6 1	neun	nonce	_						
0	Ć,	execuin and ial-trai	Exa	resulting in death) La	ist	Due to	or as a con	sequence	of):								
01507903	8760,	ate be e shysician the buria	dlcal			d											
	9	The law requires that the death certificate be executed to has been signed by the attending physician and te has been signed by the attending 2 should be detached for use as the burial-transit	ed											-			
7	Вох	eath certific attending p for use as f	Physician/Me	IF FEMALE: 23b. Was decedent p	pregnant	23c. If yes, out			ه ۵۵۰۰۰۰					2	3d. Date of de	ivery	
0	m	death e atte d for	<u>  2</u>	in the past 12 m		4□Pregn	irth 2 □ F ant at time			ic pregnancy r <i>(specify)</i>	/				Month	Day Ye	ear
-0	P.0	that the de ed by the detached	hys	9 □ Unknown		9□ Unkn	own										
0	Д,	s that ned t	by P	Part II. Other signific		_		_	the underly	ng cause giv	en in Parl	tl.	23e. Did 1	tobacco us	se contribute to	the cause of de	ath?
~ )	rds	quires n sign ald be		11	itersti	AL FIB	10515	,					1 🗆	Yes 2□	]No 3 □ P	obably 4 Ur	nknown
3	Records,	w requir been si should	lete	Acuite R	enal 1	AL FIB							24a. Was	an	24b. Were at	itoosy findings a	vailable
25/16 13/01/27 20	Re	The lay ate has page 2	Completed	7,40-70		1-01 000							auto perfe	psy ormed?	death?	topsy findings a completion of ca	use of
2	a			25 11/									1 ☐ Yes	2 1 No	1 🗆 Yes	2 No	
	ΞĘ	ysician: is certific director,	Be	25. Was case referre examiner?		Hospital:				1 DOA Oth	or		h (Check only o				
7	of	Phys	۲: ا	27. Manner of Death	10	28a. Date		2 ER/Ou 28b. 1	tpatient 3L	DOA 28c. Injur	401	-	me 5 Resi 28d. Describe			city)	
5	UQ	ding Ph h. After th funeral	tion	1 Natural	5 Pending investigation	(Mon	h, Day Year	r)   I	njury M	Wor	k? Yes 2[						
2	Si	ttandi death. stor: A / the fu	ical	2 Accident 3 Suicide	6 Could no	t be	of Injury . A	it home, fa	rm, street, fa		103 22		28f Location /	Street and	Number or R	ural Route Numb	or.
Merrit	Division	of or Attan after deat Diractor:	Certification:	4 🗌 Homicide	determin	ed buildi	ng, etc. (Sp	ecify)	in, street, ra	otory, office				wn, State)			0.,
2.00		To the Hospital or Attanding Physician: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director.		29a. Certifier	Certifying	Physician: To the	best of my	knowledos	death occur	rred at the tim	ne date en	and place	and due to the	Calleg(e)	and manner of	stated	
		24 h Fur etely	Medical	(Check only 2 one)	Medical Ex	caminer: On the b	asis of exam ner stated.	ination an	d/or investiga	ition, in my o	pinion, de	ath occur	red at the time,	date and	place, and due	to the cause(s)	
		To the within 2 To tha complet	Me	29b. Signature and ti	itle of certifier					29c. Licens	e number			29d. Date	signed (Mont	h, Day, Year)	
		F 3 F 2		1.1	11	ton M.D					129				4/11/0		
		1,00		30. Name and address		1	o of do-11.	Itom OC:	The Dis								
		11/10				I I . I .	e oi death (	nem 23a)	( ype, Pnnt)	0.71.0			- 6 1-1		, ~	u (3a14	
		Sta		Christ To 31. Date filed (Month	, Day, Year)	32. A	distrar's Si	gnature	1000	Bor		neet	Salial	sury	md o	11804	
		Registr		F	IPR 13	2005	Yatras .	K	free	R.							
				<u> </u>			Carried States	~	14	-							

		- Ticase	State of M			artment of			-		egibic.	
		1 - For State Registrar		,		tificate of				leg. No	005	4339
Dhamisi	o)	1. Decedent's Name (First, Middle, Las	t)						2. Date of Dea Month	th Day	Yeer	3. Time of Death
Physici /Medio		Frances Elizabet							April 2	21 20	005	5:00 A M
Examir	er	4a. Facility Name (If not institution, give				4b. City, Town,		of Death			County of Dea	
		St. Catherine's  5. Social Security Number 6. So			last birthday)	Emmits If Under 1 Year		r 24 Hrs.	8. Date of Birth	1	Freder:	
Funeral Director		,	□м 2[ <b>Х</b> F		3 Yrs.	Months Days	Hours	Min.	(Month, Day June 19	', Year)	31	thplace (State or Foreign ountry)  Maryland
p ,		Usual Residence of Decedent  10a. State 10b. County		100 Cib	y, Town or Lo	nation						10d. Inside City Limits
sho	ō		1-		nitsbu							1 XYes 2 No
28a-	Directo	Maryland Frederic  10e. Street and Number	.K	Eilli	HILSDU.	10f. Zip Code			1	l0g. Citiz	en of What C	ountry?
h with		331 South Seton Av	enue			21727					U.S.A.	
ems 2	ner	11. Marital Status	12. Was Decedent Armed Forces	Ever in U.	S. 13.	Was Decedent of f Yes, specify Cul	Hispanic Or	rigin? (Spec	cify Yes or No-		4. Race - Am Black, Whi	
or its	by Funeral	1 Never Married 2 Married	1 ☐ Yes 2 💢 If Yes, Give	No	1	1 ☐ Yes 2 🗶 No			, , , ,	-		White
fural Ex		3 ☐ Widowed 4 ☐ Divorced  15. Decedent's Ed	Year or Dates:		16a Dece	dent's Usual Occu	ination			16h Kin	d of Business	
nin 72	Completed	(Specify only highest gra		5.4)	(Give	kind of work done DO NOT use retire	e durina ma:	st of workin	g	100. 1411	G 9, Business	unidadiy
giene giene ar tha	Mo	0	College (1-40)	3+)	N	ever Wor	cked				Nor	ne
be file d oth d oth	Be	17. Father's Name (First, Middle, Last)	<b>.</b> .						(First, Middle,		,	
Individually Z. I.Z. 1.2-0000 2 should be filed within 72 hours after death with the Maryland 1 and Mentai Hygiene. Is marked othar than "natural", or Items 23s or 28a-1 show raumatic evant, the Mudical Edit cliner catal by nutilihad at	2	George E. Mehaf			10h tasti	- Address /Ctors	1		E. Mic			Ti- Code
s 1 and 2 should be filed within 7 fleath and Mental Hygiene. item 27 is marked othar than "n other traumatic evant, it is Media		Connie D. Boone/S				ng Address (Stree				-		MD, 21795
parimit. Pages 1 and 2 Department of Health at Important: If item 27 is any injury or other trau	-	20a. Method of Disposition			lace of Dispo	sition (Name of natory or other pla	-				ation - City or	
Darting Dermit. Page Department o mportant: If nny injury or		1   Burial 2 □ Cremation 3 □  4 □ Donation 5 □ Other (Specify				et Cemet		04/23	/2005	Fred	erick,	Maryland
permit. Departri Importa any inju		21. Signature of Funeral Service Licen		4	22	. Name and Addr	ess of Facil	lity				Church Street
2 2 2 E 2 3			Mª Millie								Frederic	k, MD, 21701
		23a. Part1. Enter the disease, or comp shock, or heart failure. List only	one cause on each I	ine.				s cardiac or	respiratory arr	est,		Approximate Interval Between Onset and Death
Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Right Lo			neumonia	t .					48 hrs.
Examiner			Advance	·	·							3 years
	ner	Sequentially list conditions, if any, leading to immediate	Due to (or as									Journ
ecuted and transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	C. Durate (co. co.									
e be ex rsician e burial	cal E	Tooland III down, saoc	Due to (or as	a consequ	derice or);							
Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and ral director, page 2 should be detached for use as the burial-transit			d									
n certii	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1 ☐ Live birth			Terreio erono on				23	3d. Date of de	livery
death	sicla	in the past 12 months? 1 ☐ Yes 2 🗶No	4 ☐ Pregnant a			Ectopic pregnand Other (specify)					Month	Day Year
that the death	Phy	9 Unknown			. Naise a far Afair		one in Box		220 Did to	<b></b>	a contribute t	o the cause of death?
ires that signed b	by	Part II. Other significant conditions of Hypertension	ontributing to death i	out not resi	uiting in the ui	nderrying cause g	Iven in Part	1.		es 2 🕱		robably 4 Unknown
w requir been s should	ompleted	Diabetes Mellit	•••		· · · · · · · · · · · · · · · · · · ·				24a. Was a	- 7		
he lav	фш	Diabetes Hellit	us		_				autops perfori	med?	prior to death?	utopsy findings available completion of cause of
ysician: The lis certificate hadrector, page	CO	25. Was case referred to medical					26. Plac	e of Death	1 ☐ Yes :		1 Ll Yes	s 2 No
nysici nis cer direci	To B	examiner? 1 Tes 2 No	Hospital: 1 ☐ Inpati	ent 2	ER/Outpatier	t 3 DOA	thor		ie 5 ☐ Reside		□Other (Spe	ecity)
dang Ph		27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	ury ay Year)	28b. Time of Injury	We	ork?		8d. Describe ho	ow injury	occurred	
r Attender death	icati	2 Accident investigation 3 Suicide 6 Could not be		ium. At he			Yes 2		9f Location /S	troot and	NumberorD	ural Route Number,
after din by	ertification:	4 Homicide determined	building, e			eet, factory, office	•	2	City or Town		Number of A	urai noute ivumber,
To the Hospital or Attending To the Hospital or Attending Within 24 hours after death To the Funalial Director: After completely filled in by the funal	O		ysicien: To the best									
ha Ho in 24 ha Fu pletel	Medical	(Check only 2 Medicel Exemone)	iner: On the basis of and manner si		tion and/or in	vestigation, in my	opinion, dea	ath occurre	d at the time, d	ate and p	olace, and due	e to the cause(s)
To t To t	Σ	29b. Signature and title of certifier	1		11 .11	29c. Licen	se number	フハて	2	9d. Date	-	th, Day, Year)
		, Ula	Lu	Lo	y M	DI	10	10)		7	. 22	1 05
1		30. Name and address of person who dearroll, MD.	·				Marul	and '	21727			
Sta	te		32. Regist	rar's Signa	ture		лагуга	، ولالت	LIILI			
Registi		31. Date filed (Month, Day, Year) APR 2 7 2005	Glasur	H	hard.							

ORIGINAL

			State of Mary		•				11.31.0
			Registrar		ertificate of l		Reg. No. 1. Date of Death	lò.	3. Time of Death
	Physicia /Medic		1. Decedent's Name (First, Middle, Last)  Richard Philip McKe	nna			Month D	ay Year	5 10:40 AM
	Examin	er	4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of Death	4	c. County of Dea	
			Citizen's Nursing Home  5. Social Security Number 6. Sex 7. Age (In	yrs. last birthda	Freder If Under 1 Year	ICK If Under 24 Hrs.   A	Date of Birth	Frede	thplace (State or Foreign
	Funeral Director		150-20-4524	79 Yrs.	Months Days	Hours Min.	Date of Birth (Month, Day, Yea eptember 10	, 1925 N	ew Jersey
	D		Usual Residence of Decedent						
	arylar show	2		c. City, Town or					10d. Inside City Limits 1   Yes 2  No
	he M	ectc	Maryland Frederick  10e. Street and Number	Frederi	10f. Zip Code		100.0	itizen of What C	**
	with with	בֿ	1900 Rosemont Avenue		21702			U.S.A.	•
	death ms 2	nera	11. Marital Status 12. Was Decedent Ever Armed Forces?	in U.S. 1	3. Was Decedent of H	ispanic Origin? (Speci n, Mexican, Puerto Ri	ify Yes or No-	14. Race - Am	erican Indian,
9	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show ha Medical Examir et mast be multified at	by Funeral Director	1 Never Married 2 Married 1 Yes 2 XNo		1 ☐ Yes 2 No	Specify:	carr, etc.)	Black, Whi	White
21215-0036	hours ural',	d b	3 ☐ Widowed 4 ☑ Pivorced Year or Dates:	160 Do	cedent's Usual Occup		16h	Kind of Business	
15	in 72 "nat	olete	15. Decedent's Education (Specify only highest grade completed)	(G	ive kind of work done on the contract of the c	during most of working		Autu of Busiliess	virioustry
212	d with giene.	Completed	Elementary/Secondary (0-12) College (1-4or 5+)		Technical	Writer	Res	earch and	Development
pu	al Hyg	Bec	17. Father's Name (First, Middle, Last)			18. Mother's Name (	First, Middle, Maid	en Sumame)	
Maryland	ould b Ment arkac	0	Philip J. McKenna			Helen	Feld		
Mar	12 sh h and 7 is m traum		19a. Informant's Name/Relationship (Type, Print)  Michele A. McKenna/Daughter		ailing Address (Street:  1 Frederic				
e,	1 and Health em 2			20b. Place of Dis	sposition (Name of	Da		Location - City or	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evantine must be notified at once.		1 Burial 2 Cremation 3 Removal from State	-	crematory or other place urg Cremat		2005 Sm	thehuro	, Maryland
alti	mit. F partme portar / injur		21. Signature of Funeral Service Licensee		22. Name and Addre		2005		t Church Street
m	D T E G		P. Kran Mª Millian		Keeney and Ba	sford P.A. F	uneral Home	Frederi	ck, MD, 21701
П			23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line.	death. Do not	enter the mode of dyin	g, such as cardiac or	respiratory arrest,		Approximate Interval Between Onset and Death
	Priysician		Immediate Cause (Final disease or condition resulting in death)	emm	ec				3 dess
	/Medical Examiner		Due to (or as a co	nsequence of):					
		ē	Sequentially list conditions, if any, leading to immediate b. Due to (or as a co	onsequence of):					-
V	uted d ansit	Examine	cause. Enter Underlying Cause. Design of the state of the						
ó	sician and burial-transit		resulting in death) Last Due to (or as a co	insequence of):					
8760	₹ ≥ ĕ	dical	d						
9	death certifica attending ph d for use as th	Physiclan/Med	IF FEMALE: 23c. If yes, outcome of p	eregnancy				22d Date of de	divor
Вох	eath c atten	clan	in the past 12 months?	Fetal death	3 Ectopic pregnancy 5 Other (specify)	,		23d. Date of de Month	Day Year
0	t the de by the a tached	hysi	1 Yes 2 No 9 Unknown						
S, P	es that igned t be det	by P	Part II. Other significant conditions contributing to death but no	ot resulting in th	e underlying cause giv	en in Part I.		_	o the cause of death?
ord	w require been sig should b	ted	Chron detructure por	dnin	y del	eace	1 Yes	2 ☑ No 3 ☐ P	robably 4 Unknown
Records,	e law re has be je 2 sho	Completed	Clementre				24a. Was an autopsy	prior to	utopsy findings available completion of cause of
al H							performed		s 2 No
Vital	Physician: Tribis certificateral director, p.	Be	25. Was case referred to medical examiner?  Hospital:		tiont 20 DOA Cth	er: . Diace of Death	Check only one)  Beginsterned	0 Flore /0-	
of	Phys ar this aral di	To To	1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 27. Manner of Death 28a. Date of Injury.	2 ER/Outpa 28b. Tim	e of 28c. Injur	4 Denvirsing Home	d. Describe how in		эспу)
ion	utending F death. ctor: After / the funera	ation	1 Land Natural 5 Pending (Month, Day Ye 2 Accident investigation	ea <i>r)</i> Injui		K? Yes 2 □ No			
Division		ertification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury-building, etc. (5		street, factory, office	28	Bf. Location (Street City or Town, St		tural Route Number,
Q	urs aff	O							
	To the Hospital or a within 24 hours after To the Funeral Direction completely filled in L	edical	29a. Certifier 1 ☐ Certifying Physician: To the best of m (Check only one) 2 ☐ Medical Examiner: On the basis of exc and manner stated	amination and/o	eath occurred at the tir r investigation, in my o	ne, date and place, ar pinion, death occurred	d at the time, date a	(s) and manner a ind place, and du	s stated. e to the cause(s)
	o the	Me	29b. Signature and title of certifier		29c. Licens			Date signed (Mon	
	C > F 0		Many Elsen	les M.	0 03	0496	4	122/0	50
			30. Name and address of person who completed cause of death	n (Item 23a) (Ty	PD 03 pe, Print) SO W. 37		~ /		2 4 5
	3		Francis 12. Beiler M.	0,30	50 10.97	1/11/17	referrely	Md	61701
	Sta Registr		31. Date filed (Month, Day, Year) APR 2 7 2005	Signature	adis				
	riogioti		The state of the s	No.					

			For Amend Item	State of Ma 23c&25 per m &23a-b					•		0 0 5	14341
			Decedent's Name (First, Middle,						2. Date of De	ath		3. Time of Death
	Physici		DANIEL HASTINGS	PUSEY, JR.					Month 04	Day 13	2005	08:10P M
	/Medic Examin		4e. Fecility Name (If not institution,	give street and number)		4b. Cit	y, Town, or Lo	ocation of Death	L	4c. Co	unty of Death	
			3628 MEADOWBRID	GE ROAD			SALIS	BURY			WICOMI	CO
	Funeral		5. Social Security Number 6		(In yrs. last bii	Month		f Under 24 Hrs. Hours Min.	8. Date of Bin (Month, Da 11-07-	h v. Yeer)	9. Birth	place (Stete or Foreign ntry)
100	Director		215-36-1826	1 □ M 2 □ F	65	Yrs.			11-07-	(939	SALI	SBURY, MD.
	and *		Usual Residence of Decedent  10a. State 10b. County		10c. City, Tow	m or Location						10d. Inside City Limits
	anyla	5	,	COMTCO	SALIS							1 ☐ Yes 2 No
	the A	Director	MD WI  10e. Street and Number	COMICO	SALIS		Zip Code			10a Citiza	n of What Cou	
	with			OF BOAD		101. 2		100/		rog. Citizei		nu y :
	ne 23	Funeral	3628 MEADOWBRID  11. Marital Status	12. Was Decedent E	Ever in U.S.	13. Was Dec		1804	ecrfy Yes or No	- 14	USA Race - Ameri	can Indian
10	r from	F	1 Never Married 2 X Marrie	Armed Forces?				eanic Origin? (Sp Mexican, Puerto	Rican, etc.)		Black, White,	
93	urs a	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes	2 🛣 No	Specify:		Sp	pecify: W	HITE
9	72 ho	Completed	15. Decedent's (Specify only highest	Education	16a	. Decedent's Us	sual Occupation	on ring most of work	ina	16b. Kind	of Business/In	dustry
21	thin 7	ple	Elementary/Secondary (0-12)	College (1-4or 5	+)	life. DO NOT	use retired)	ing most of work	iii g			
21	ed wi	Co	11			REP	AIRMAN					COMPANY
nd	be filed within 72 hours after deeth with the Maryland ital Hygiene. Id other then "netural", or Iteme 23e or 28a-f ehow event, the Medicial Exciplest must be notilized at	Be	17. Father's Name (First, Middle, La				1	8. Mother's Nam	e (First, Middle,	Maiden Su	тате)	
yla	Men Men arke	ို	DANIEL HASTINGS				0	LA MURI	EL WILL	ING		
a	2 sh and is m		19a. Informant's Name/Relationshi					d Number or Rur				
2	and lealth m 27 her to		KATHLEEN PUSEY	- SPOUSE				GE ROAD				
0	H ite		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation	B □Removal from State	cemete	of Disposition (N ory, crematory or	r other place)		Date	20c. Locat	tion - City or T	own, State
Ë	meni tant: jury		* 4 ☐Donation 5 ☐ Other (Spe	ecify)	SPRIN			S. 04-1			N, MAR	
Baltimore, Maryland 21215-0036	permit. Peges 1 and 2 should be filed within 72 hours after deeth with the Marylan Department of Health and Mental Hygiene.  Department of Health and Mental Hygiene.  Important: if item 27 is marked other than "neturel; or iteme 23e or 28e-1 e-how environger or other treumatic event, the Medical Examiner must be notified at an once.		21. Signature of Funeral Service Li	censee	. 4			of Facility BO			-	
	20 = 0		111150	ley Heel	M						MARYLA	ND 21804
. 8			23a. Part 1. Enter the disease, or c shock, or heart failure. List	proplications that caused my one cause on each lin	the death. Do	not enter the mi	ode of dying,	such as cardiac	or respiratory a	rrest,		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	_ a		cemia						Hologo
	Examiner		•	Due to (or as a	a consequence			1				- / 4
-		<u>a</u>	Sequentially list conditions, if any leading to immediate	b. Due to (or as a	infec		Weur	2 of		1	-	3 months
	nsit	nin	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events			s melli	tus				7	
-	e be executed rsicien and e burial-transit	Examiner	resulting in death) Last	U	a consequence		cus	$\triangle$	TON APPROVED	/	MAINER	
760,	te be ex ysicien ye burial	cai		d				/_]	//	MEDICAL	EXPAN.	
.89				V					POROVED	6.00		
X	Attending Physician: The law requires that the death certificate relath.  •closth.  •clor: After this certificate has been signed by the attending phy. the funeral director, page 2 should be detached for use as the	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome		- 0-		CERTIFIC	40h 4	230	I. Date of deliv	ery
ğ	death e atte d for	icia	in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant at		1 3 ☐Ectopic 5 ☐ Other (		CEV.			Month	Day Year
0	t the	hys	9 □ Unknown	9□ Unknown				/				
<u>ب</u>	w requires that the de been signed by the s should be detached	by P	Part II. Other significant condition	s contributing to death bu	ut not resulting i	in the underlying	cause given	in Part I.	23e. Did t	obacco use	contribute to t	he cause of death?
ğ	quire an sig uld b	pa	· Conges	Time Carde	inya	rather			10	Yes 2□N	No 3□ Prot	pably 4 Unknown
S	law re as bee 2 sho	Completed	Chron	io Poul	J-flas	Pul .			24a. Was		4b. Were auto	opsy findings available
Re	vician: The lav certificate has rector, page 2	mo								rmed?	death?	mpletion of cause of
TE/	an: T	BeC	25. Was case referred to medical				2	6. Place of Deat	1 Yes		1 🗆 Yes	2 No
<u> </u>	ysici is cer direc	To B	examiner?	Hospital:	nt 2 ER/O	utpatient 3 [	Other	4 Nursing Ho			Other (Specia	(v)
20	g Ph er th		27. Manner of Death	28a. Date of Injur (Month, Day	y 28b.	Time of	28c. Injury a Work?		28d. Describe			7/
ivision of Vital Records, P.O. Box 68	ttendin death. stor: Aft the fur	atlo	1 Natural 5 Pending 2 Accident investiga		1841)	Injury M		s 2 No				
T.S	er de	Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin		ury - At home, fa	arm, street, facto	ory, office		28f. Location (S	Street and N	lumber or Run	al Route Number,
0	tal or A	Cer		building, ord	. (Opoony)				Ony or ro	···, Olale)		
	hour uner ly fill		29a. Certifier 1 Certifying	Physician: To the best of	of my knowledg	e, death occurre	ed at the time,	date and place,	and due to the	cause(s) an	d manner as s	tated.
	To the Hospital or Attending Physician: The I within 24 hours after death.  To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Medicai	one)	xaminer: On the basis of and manner sta	ted.	nwor investigatio	on, in my opin	non, death occur	red at the time,	date and pla	ace, and due t	o tne cause(s)
	To t To t	Σ	29b. Signature and title of certifier	2 5	///	2	9c. License n	umber		29d. Date s	igned (Month,	Dey, Year)
			1 ( Ale	X 5/	have	MN	10-	2000	50	1	4/15/	5-
		I	30. Name and address of person w	no completed cause of de	eath (Item 23a)	(Type, Print)		62 0		1 -	/ - / -	10
-			Bexito c	S. (han	RO.	1340	South	Divis	Jun 57.	Sul	800/	Sily 41)
	Sta Regist		31. Date filed (Month, Day, Year) APR 1 5	2005 32. <b>33</b> gistra	ar's Signature	Ann. V.						Sely 40
- 16	THE CIST	reil 💮				4.500						/

State of Maryland / Department of Health and Mental Hygiene State
Registrar amend item #19b per fh/wchd/Certificate of Death4-13-05/dlsreg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death Month **Physician** Year 2005 ELWOOD BAILEY PRICE /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Peninsula Regional If Under 1 Year If Under 24 ICAL CENTE WICOMICO 5. Social Security Number 7. Age (In yrs. last birthday 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1⊠M 2□F 81 Yrs. Director 214-18-4946 May 14. 1923 Maryland Usual Residence of Decedent the Maryland 10c. City. Town or Location 10a State 10h Counts 10d. Inside City Limits 28a-f shov other traumatic evant, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Worcester Snow Hill 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 items 23a 408 Covington Street 21863 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🖾 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 □ Never Married 2 □ Married ō 1 ☐ Yes 2 🖾 No Specify: Specify. 3 Widowed 4 □ Divorced "natural" Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) d 2 should be filed within 7 in and Mental Hygiene. 7 is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) laborer Lumber Company 6th Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be unknown Ida Mae Price 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 is m any injury or other traum once. 1210 Elmridge Avenue - Baltimore, MD Ms. Valerie Price/daughter 21229 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 🔀 Burial 2 ☐ Cremation 3 ☐ Removal from State \* 4 □ Donation 5 □ Other (Specify) Hutt Mem. Ch. Cem. 104/14/2005 Snow Hill, Maryland 22. Name and Address of Facility 1213 Jersey Road - Salisbury, MD 21. Signature FyFuneral Service Licenses 21801 JOLLEY MEMORIAL CHAPEL 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examine use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last 4 2-1 Due to (or as a consequence of) attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No ģ Month Day Year 4□Pregnant at time of death 5 Other (specify) P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a Wasan 2 1NO 1 Yes Physician: funeral director. Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 € No Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Division Hospital or Attending 1 Natural 5 Pending after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To tha Funeral D Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) William KOBINS 1.0 CARKOII 100 31. Date filed (Month, Day, Year) 32. pgistrar's Signature APR 1 3 2005 Registrar

			1 - For State Registrar			nd / Depa		t of H	ealth a			giene Reg. No.	000	11.3	43
п	Physici		1. Decedent's Name (First, Middle, L Ruth Elizabeth								2. Date of Dea Month April	Day	2005	3. Time of 1	Dea <sup>‡</sup> th M
	/Medic Examin		4a. Facility Name (If not institution, g Beverly Healthc	ve street and nu	mber)			Town, or	Location o		April	4c. C	County of Death redericl		
	Funeral Director		213-16-1438	Sex 1□M 2⊠XF	7. Age (In yrs. 92		If Under Months	1 Year Days	If Under: Hours	Min,	8. Date of Birt (Month, Day May 28	h , <i>Year)</i> 1912	Cou	olace (State or ntry) CO.,	
	yland 10W		Usual Residence of Decedent  10a. State 10b. County		10c. Ci	ity, Town or Lo	ocation							10d. Inside Cit	y Limits
	Ba-f st	ctor	MD Frede	rick	В	runswic	k							1X Yes	2□No
	th with th	Funeral Director	10e. Street and Number 1100 Peach Orcha	rd Lane			10f. Zip	217	16				en of What Cou SA	ntry?	
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: if itam 27 is marked other than "natural", or itams 23a or 28a-f show amy injury or other traumatic avant, the Medical Exscriber must be notified at ance.	by	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. Was Dec Armed Fo 1 Tes If Yes, Giv Year or D	2⊠No ve		Was Deced If Yes, spec	ify Cuba	spanic Oric n, Mexican Specify:	gin? (Spe i, Puerto l	ecify Yes or No- Rican, etc.)		4. Race - Amen Black, White, Specify: W		
Maryland 21215-0036	vithin 72 ho ne. han "natur n Medical	Completed	15. Decedent's (Specify only highest g		1-4or 5+)	16a. Dece (Give life.	dent's Usua kind of wor DO NOT us	rk done d se retired	luring most )	t of worki	ng		d of Business/Ir	•	
5 9	filed v Hygie othar t		12 17. Father's Name (First, Middle, Las	t)			House	MILE		r's Name	(First, Middle,			-	
/lan	should be nd Mental a marked o umatic ave	To Be	Jeffrey Butler						Les1:	ie Ma	artin				
	and 2 sho ealth and n 27 is ma		19a. Informant's Name/Relationship Marna Switlick,		•								Town, State, Zip n , MD 21		
altimore,	Pages 1 a nent of He int: If itam iry or othe		20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3	☐Removal from		Place of Dispo cemetery, crea					ate		ation - City or T		
Ē	iit. Pag intment intant: njury o		* 4 □ Donation 5 □ Other (Spec 21. Signature of Fundal Service		Pa		_						swick, 1	ID	
Ba	permit. Departr Importa	1	Burrow	lliams,	Owner						neral H		k, MD 21	716	
	ate be executed /Medical Examiner the burial-transit	ical Examiner	23a. Part1. Enter the disease, or co shock, or heart failure. List only immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, and cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a	eaused the dealeach line.  Metaleach consecutive as a con	quence of):	er the mode	e of dying	, such as	cardiac o	r respiratory ar	PVI	mary	Approximate Interval Betwood Onset and D	eath
.O. Box 68	ath certific ttending p or use as	Physician/Medio	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 S No 9 □ Unknown	1 Live b	tcome of pregn birth 2 Feta nant at time of cown	al death 3	□Ectopic pre □ Other (spe					23	3d. Date of delive	,	ear ear
ds, P	juires that the de signed by the a lid be detached f	by	Part II. Other significant conditions	contributing to d	eath but not res	sulting in the u	nderlying ca	ause give	en in Part I.		23e. Did to	_	e contribute to t	ne cause of de	
al Records,	aician: The law requird certificate has been si- irector, page 2 should b	Completed									24a. Was autop perfor 1 \( \text{Yes} \)	sv	24b. Were auto prior to co death? 1 ☐ Yes	mpletion of car	vailable use of
Vital	Phyaician: r this certificaral director,	o Be	25. Was case referred to medical examiner?  1 Yes 2 No	Hospital:	Inpatient 2	ER/Outpatier	nt 3 DO	Othe			(Check only of		□Other (Specif		
Division of	Attanding Phy r death. actor: After this by the funeral d	$\vdash$	27. Manner of Death  1 Natural 5 Pending 2 Accident investigati	28a. Date (Mon		28b. Time of Injury		Bc. Injury Work		2	28d. Describe h			y)	
Divisi	i Sir fe	Certification:	3 Suicide 6 Could not determine	be 28e, Place	of Injury - At h	ome, farm, str	reet, factory	, office		- 2	28f. Location (S City or Tow		Number or Rura	I Route Numb	er,
	To the Hospital within 24 hours a To tha Funeral Completely filled	Medical C	29a. Certifier 1 Certifying F (Check only one) 2 Medical Ex	hysician: To the miner: On the b and man	best of my kneasis of examination	owledge, death ation and/or in	h occurred a vestigation,	at the tim in my op	e, date and inion, deat	d place, a	and due to the dead at the time, d	ause(s) a date and p	and manner as s place, and due to	tated. the cause(s)	
	To the within To the comp	Me	29b. Signature and title of certifier	io N	ND		29c	-	number 22	03-			signed (Month,		
	7		30. Name and address of person wh	completed caus	se of death (Ite	m 23a) (Type,		05	Br	Lakari	wick.	u)	2171	/.	
	Sta Registr		31. Date filed (Monting PR Year) 4		istrar's Sign	ature			-	V. T. T.	(		J-1. 1.		

		1- For Amend Ite Registrar  1. Decedent's Name (First, Middle)	a 25tate et M	<b>9</b> Eyla <b>G8</b> 4	( <b>5),</b> (0) Ce	rtificate	of E	paith a Death	and M		ag. No,	75	1 + 2 1 1
Physici /Medic		Richard	Anthony R		son,	1				Month April 7	Day	Year 5	3. Time of Death
Examin	er	4a. Facility Name (If not institution		)		4b. City, T		Location of	of Death		4c. County	of Death	
		Southern Maryland		ma //m .um /m at	to football at a cal	Clin	ntan	If Under	04 Hea T		Prince		
Funeral Director		5. Social Security Number  577–90–8496  Usual Residence of Decedent	6. Sex 7. A	ge (In yrs. last	Yrs.		Days	Hours	Min.	8. Date of Birth (Month, Day January 8	, Year)	9. Birthp Cour D.	place (State or Foreigntry) C.
land ow		10a. State 10b. County		10c. City, T	own or Lo	ocation						1	I0d. Inside City Limit
Mary -f sh	ğ	MD Prince	: George's		Clinto	m							1⊠Yes 2□N
r 28e	Director	10e. Street and Number		.1		10f. Zip 0	Code				l0g. Citizen of	What Cour	ntrv?
3a o		9211 Stuart Lane					207	735			U <b>.</b> S		,
deat deat	ner	11. Marital Status	12. Was Decedent	Ever in U.S.	13.	Was Decede	nt of His	spanic Ori	gin? (Spe	ecify Yes or No- Rican, etc.)	14. Rad	e - Americ	
2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural, or items 23a or 28e-f show aumatic event, the Madical Examiner must be notified at	by Funeral	1 XNever Married 2 ☐ Mar	Armed Forces' ned 1 ☐ Yes 2 ☑ If Yes, Give			1 ☐ Yes 2			i, Puerto I	Hican, etc.)		ck, White,	
urai',	b D	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:			10195 2	A 140	Specify:			Specif	y: Bla	ck
72 h 'natu	Completed	15. Deceder (Specify only highe	t's Education st grade completed)	1	(Give	dent's Usual kind of work	done d	uring mas	t of workir	ng	16b. Kind of B	usiness/in	dustry
han '	Id III	Elementary/Secondary (0-12)	College (1-4or	5+)	life.	DO NOT use	retired)				Truckir	m	
led v lygie her t		12				Drive			_				
d ta b	Be	17. Father's Name (First, Middle,								(First, Middle,		ne)	
should ind Men marke umatic	ပ	Richard Anthony I	***							. Tolli			
		19a. Informant's Name/Relations Andrea Richardson								l Route Numbe			Code)
l and lealth im 27 her tr			-SISCEL			and the same of the same of		n len	B1 20 10 10 10 10 10 10 10 10 10 10 10 10 10	Hyattsvi			
Pages 1 nent of H int: If ite		20a. Method of Disposition 1 Durial 2 Cremation	3 ☐Removal from State	ceme	etery, cre.	osition (Name matory or oth	ier place				20c. Location	-	
Part in		'4 ☐ Donation 5 ☐ Other (S		River					_	18, 2005		•	
pernit. Pages 1 a Dej artment of Hes Importent: If item any injury or othe		21. Signature of Funeral Service	Licensee CO	Pier	2					ette & Ass DC 20018	cc. Fure	ral Ho	me Inc.
Medical Examiner  bhysicien and sthe burial-transit	icai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Industrying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as	s a consequent	ce of):	Pive	ite	ng	te	n Cey i			
The law requires that the deeth certificate be executed to has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	by Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal de	ath 3[	U □Ectopic prec □ Other (spec						te of delive	ery Day Year
ned ben	y P	Part II. Other significant condition	ons contributing to death I		-	, -	-	n in Part I.		23e. Did to	bacco use conf	tribute to th	ne cause of death?
w require been sig should b		100	Cos Mucc	Brono	hial	Asth	na			1 □ Y	es 2 🗆 No	3 🗌 Prob	ably 4 Unknov
s bee	Completed	(4)	cignon.	- Seizu	ıre					24a. Was a		Were auto	psy findings availab
Tha fav te has age 2	E									autops	ned?	death?	impletion of cause of
	a)	25. Was case referred to medica						26 Place	of Death	1 ☐ Yes (Check only or		1 🗌 Yes	2 No
Physician: Tha i this certificate he ral director, page	0	examiner? 1 ☐ Yes 2 1 No	Hospital	ient 2 ER/	/Outnatie	nt 3 DOA	Othe			ne 5 Reside		or (Specif	ul
g Physer this eral di	n: T	27. Manner of Death	28a. Date of Inju		b. Time o		c. Injury Work			28d. Describe h			//
ndin tth. :: Aft	atio	1 Natural 5 ☐ Pendir 2 ☐ Accident investi		ay rear)	Injury	м		? ′es 2 🔲 i	No				
al or Atte safter des 1 Director d in by th	Certification;	3 Suicide 6 Could 4 Homicide determ	ined 286. Place of In	jury - At home tc. <i>(Specify)</i>	, farm, st	reet, factory,	office		2	28f. Location (Si City or Town		er or Rura	l Route Number,
To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medicai C	29a. Certifier 11 Certifyir (Check only one) 1 Medical	ng Physician: To the best Examiner: On the basis of and manner st	of examination	dge, deat and/or in	h occurred at vestigation, in	t the time	e, date ani inion, dea	d place, a th occurre	and due to the c ed at the time, d	ause(s) and ma ate and place,	anner as st and due to	ated. the cause(s)
ompl	Me	29b. Signature and title of certifie				29c.	License	number		2	9d. Date signe	d (Month,	Day, Year)
->-0		1 dean	AL alfu	sel 7	,	7	20	01.10	08		4:0	7.)	00,
(1)		30 Name and address of passes	who completed saves of	doath (lta= 00	(a) (T:	Deine Till	20	271	20	26426	0		
-0		30. Name and address of person ABULH ASA	N ANSAR	(MI)		2(1/4)	w	W	Q.	120	35	æ	101
Sta	ite rar	31. Date filed (Month, Day, Year)	Regist	rar's Signature	1								

		State of State of Pagistrar		partment of Head (843) entificate of De	alth and Me 05, tas eath	ntal Hygier		14345
Physic /Medi Examir	cal	Decedent's Name (First, Middle, Last)     Eric Andrew Renton      4a. Facility Name (If not institution, give street and numb      531 HIGHLAND DRIVE	er)	4b. City, Town, or Loc EDGEWATER	A		Oay Year O, 2005 4c. County of Death NNE ARUNI	3. Time of Death 4:20p M
Funeral Director			Age (In yrs. last birthda 45 Yrs.	y) If Under 1 Year   If	Hours Min.	Date of Birth (Month, Day, Ye		nplace (State or Foreign untry)
ith the Maryland or 28a-1 show	Director	10a. State 10b. County  Maryland Anne Arundel  10e. Street and Number	10c. City, Town or	Location Igewater 101. Zip Code		10g.	Citizen of What Co	10d. Inside City Limits 1 ☐ Yes 2 No untry?
be filed within 72 hours efter death with the Maryland tal Hygiene. Id other than "natural", or itema 23a or 28a-1 show event, I're Medical Examinar must be ricitlised at	by Funeral I	531 Highland Drive  11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Zipivorced  1 12. Was Deceded Armed Force 1 12. Yes 2 1 12. Yes 2 1 13. Yes 2 1 14. Yes 2 1 15. Yes 2 1 15. Yes 7 1 15. Yes 7 1 16. Yes 8 1 16. Yes 8 1 16. Yes 8 1 16. Yes 8 1 16. Yes 8 1 16. Yes 8 1 16. Yes 8 1 16. Yes 8 1 16. Yes 8 1 16. Yes 8 1 16. Yes 9 1 16. Yes 8 1 16. Yes 8 1 16. Yes 9 1 16.	ent Ever in U.S. 13 es? No No	2103° 8. Was Decedent of Hispa If Yes, specify Cuban, M	<del></del>	y Yes or No- an, etc.)	USA  14. Race - Americal Black, White Specify: Wh	, etc.
inal yearly structory of structory of 2 should be filed within 72 hours of the and Mental Hygiene. It is marked other than "natural, or traumatic event, The Medical Exam.	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4	or 5+)	cedent's Usual Occupation ve kind of work done dunir DO NOT use retired)	ng most of working	F	Kind of Business/	
all y la	To Be	17. Father's Name (First, Middle, Last)  Charles Anthony Ren:  19a. Informant's Name/Relationship (Type, Print)		iling Address (Street and		hyllis G	ottfried	ïp Code)
as 1 ar		Phyllis S. Walt/ Mother  20a. Method of Disposition  1 □ Burial 2XX remation 3 □ Removal from State  4 □ Donation 5 □ Other (Specify)	20b. Place of Dis	Hunters Ric position (Name of rematory or other place) rematory	dge Rd. 4-22-	20c.	MA 01742 Location - City or 1 dgewater,	Town, State
permit. Page Depertment of important: If any injury or		21. Signature of Funeral Sarvice Licensee  23a. Part 1. Enter the disease, or complications that cau		22. Name and Address of 2973 Solomor	ns Island	Rd. Edg		
Physician / Medical Examiner percented private private frausit private frausit private frausit private private frausit private	lical Examiner	Sequentially list conditions, if any, leading to immediate cause. Ener underlying Cause (Disease or injury that initiated events c.	as a consequence of): as a consequence of): as a consequence of):	osis				Interval Between Onset and Death
at the death certifica by the attending ph tached for use as th	Physician/Med		n 2 Fetal death 3 It at time of death 5	B Ectopic pregnancy			23d. Date of deliver Month	very Day Year
The law requires that the law been signed by the vage 2 should be detached.	þ	Part II. Other significant conditions contributing to deal Chronic Alcoholism	h but not resulting in the	underlying cause given in	n Part I.		o use contribute to	the cause of death?
	Be Completed	25. Was case referred to medical examiner?		26	6. Place of Death (C	24a. Was an autopsy performed 1 Yes 2 1 Check only one)	prior to co	opsy findings available ompletion of cause of 2 No
Phy raid in this	Certification: To I	1 XYes 2 No Hospital: 1 Inp  27. Manner of Death 1 Natural 5 Pending investigation 2 Accident investigation 3 Surjected 6 Could not be	njury 28b. Time Day Year) Injury	of 28c. Injury at Work?  M 1 Tyes	2 No	I. Describe how in		
oral lec		determined 288. Place of	Injury - At home, farm, s, etc. (Specify)  est of my knowledge, de s of examination and/or	ath occurred at the time, o	date and place, and	City or Town, Sta	(s) and manner as	stated.
To the Hosp within 24 hol To the Fune completely fi	Medical	29b. Signature and title of certifier  Weekland Mr. H.	stated.	29c. License nu			Date signed (Month)	
Sta	ate	30. Name and address of person who completed cause of the source of the	istrar's Signature	111 Pe	nn Street	Baltin	nore, Mar	yland 21201
Regist		APR 2 7 2005	w to do	all of				

			1 - For State Registrar	State of Ma	-	artment of ertificate o		d Mental Hy	giene Reg. No. 20	05 14.31.4
	Physici	an	1. Decedent's Name (First, Middle, Las					2. Date of Dea Month	ath Day Y	a. Time of Death
	/Medic Examir		4a. Facility Name (If not institution, give	street and number)		4b. City, Town	, or Location of D	Peath O H	4c. County of	
			UNIVERSITY OF M		LEOICAL CENTE	-	LTIMORE	Um To a state		
	Funeral Director		5. Social Security Number  217-46-5780  Usual Residence of Decedent	X M 2□F	(In yrs. last birthda 57 Yrs.	Months Day		Hrs. 8. Date of Birt Min. (Month, Da June 18	y, Year) 9 , 1947 [	Birthplace (State or Foreign Country)  New York
	ryland how		10a. State 10b. County		10c. City, Town or	Location				10d. Inside City Limits
	the Ma	Director	Maryland Carol 10e. Street and Number	ine	Prest	On 10f. Zip Code			10g. Citizen of Wha	1 Yes 2 No
	h with		7549 Harmony Ro	- d		216			United S	
336	be filed within 72 hours after death with the Maryland ital Hyglene. id other than "netural", or Itams 23a or 28e-f show event, I'm Neulical Examination indiffical at	by Fune	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent E Amed Forces? 1 ☐ Yes 2 ☐ X If Yes, Give Year or Dates:	Ever in U.S. 13		f Hisp <i>an</i> ic Origin' uban, Mexican, P	? (Specify Yes or No- uerto Rican, etc.)	Specify:	American Indian, White, etc.  aucasian
21215-0036	72 hor	Completed	15. Decedent's Ec (Specify only highest gra	lucation de completed)	(Gh	edent's Usual Occ e kind of work do	ne during most of	working	16b. Kind of Busin	
2121	filed within Hygiene.  Sther than "ent, I've Men.	omp	Elementary/Secondary (0-12)	College (1-4or 5	+)	DO NOT use ret	- 1	nager	Space f	light center
nd	be filed tal Hygid d other	Be	17. Father's Name (First, Middle, Last)	<u> </u>		ucy II	18. Mother's	Name (First, Middle,	Maiden Sumame)	right center
Maryland	Mer Mer marke	2	John Ja  19a. Informant's Name/Relationship	mes Schia		ling Address (Stre		hel M. Co		nto Tin Code)
	d2 s h ar 7 ts treu		Debra Schiavon			9 Hamor		Preston.		
Baltimore,	of of		20a. Method of Disposition 1 ☐ Burial 2 ☐ € remation 3 ☐		20b. Place of Dis	oosition (Name of ematory or other p	lace)	Date	20c. Location - Cit	
Itim			<ul> <li>4 □ Donation 5 □ Other (Specify</li> <li>21. Signature of Funeral Service Licer</li> </ul>	)		ol Cremat 22. Name and Add		18/2005	Dover, D	
Ba	permit. Departr Importe eny inju		Kaudskh	Mour	\ <b>V</b>	loore Fu	neral F	Home, P. A d Street	A. Dento	21629 n, Maryland
1	Physician		23a. Part1. Enter the disease, or com- shock, or heart failure. List only Immediate Cause (Final disease or condition	olications that caused one cause on each lin	the death. Do not e e.	nter the mode of d	lying, such as car	diac or respiratory ar	rest,	Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)		consequence of):					
		Jer	Sequentially list conditions, if any, leading to immediate cause.	b. Due to (or as a	consequence of):					
	ecuted and transit	Examine	Cause (Disease or injury that initiated events resulting in death) Last	c.						
8760,	sate be executed physician and the burial-transit	dical E		d do to to to as a	a consequence of):					
9	rtificate ng phy: as the	Medic	IF FEMALE:	. u.						
О. Вох	at the death certifica by the attending phatached for use as t	Physician/Me	23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown	23c. If yes, outcome of the little birth 4 Pregnant at 9 Unknown	2 Fetal death 3	☐Ectopic pregnal ☐ Other (specify)			23d. Date of Month	,
s, P	as the	by Pi	Part II. Other significant conditions of	ontributing to death bu	it not resulting in the	underlying cause	given in Part I.	23e. Did to	3.4	ite to the cause of death?
ord	w require been si should b		DIABETES ME	-4715				_ 101		Probably 4 Unknown
Vital Record	The la ate has page 2	Completed						24a. Was autop perfo 1 □ Yes	prio priod? dea	re autopsy findings available r to completion of cause of th? Yes 2 \sum No
Vita	Physicien: Th this certificate ral director, pag	o Be	25. Was case referred to medicat examiner? 1 XYes 2 ☐ No	Hospital: 1 X npatie	2   SB/Outo at	all DO4	\ther.	Death (Check only o		
ion of	ing After une		27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injur (Month, Day	v 28b. Time	of 28c. In	4   Nursir	ng Home 5 ☐ Resident Properties 1	now injury occurred	(Specify)
Division	늘하는	Certification;	3 Suicide 6 Could not by determined	28e. Place of Injubuilding, etc	ry - At home, farm, s . <i>(Specify)</i>	street, factory, office	28	28f. Location (S City or Ton		or Rural Route Number,
	To the Hospital of within 24 hours at To the Funerel D completely filled it	edical	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	ysician: To the best of niner: On the basis of and manner sta	examination and/or	ath occurred at the investigation, in m	time, date and pl y opinion, death o	lace, and due to the occurred at the time,	cause(s) and manne date and place, and	er as stated. I due to the cause(s)
	To the within To the Comp	Me	29b. Signature and title of certifier	1		29c. Lice	nse number		29d. Date signed (A	Month, Day, Year)
			7 cherte	Cuy no			P# 1762	a	4/16/	05
			ROBERT E R	EIF MD	eath (Item 23a) (Typo	, Print)	E 57	BALTIMOR	E MN	21201
	Sta Registr		31. Date filed (Month, Day, Year)		r's Signature	att)	**			

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death **Physician** Bonnie 5:36 p M Southard ADPI 2005 /Medical 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death University of Maniland Medical System Baltimore Baitimore | Honder 1 Year | Honder 24 Hrs. | B. Date of Birth (Month, Days Hours Min. Oct. 5,1947 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral**  Birthplace (State or Foreign Country) 1 ☐ M 2 🙀 F 218-50-1513 Director 57 Marvland Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location "natural", or items 23a or 28a-f show ofical Examinating at 10d. Inside City Limits Director MD Caroline 1 Yes 2 No Federalsburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 27525 Briggs Lane death v United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Pages 1 and 2 should be filed within 72 hours after of the file and Mental Hygiene.
ant: If item 27 is marked other than "natural", or item.
ary or other traumatic event, the Medical Examinal Black, White, etc. 1 Never Married 2 Married ☐ Yes 2 No Baltimore, Maryland 21215-0036 þ 1 ☐ Yes 2 ▼ No Specify: 3 Widowed 4 Divorced Specify: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Wal-Mart Company  ${f Salesperson}$ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Claude Scott Meredith 0 Hazel Wheatley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27525 Briggs Lane, Federalsburg, MD 21632 James Wayne Southard/Spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. Bloomery Cem. \* 4 ☐ Donation 5 ☐ Other (Specify) 04/19/05 Federalsburg, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Framptom Funeral Home, P.A. Michael 7 Eskeni 216 N. Main St., Federalsburg, MD 21632 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Cerebrovascular Accident **Physician** /Medical Examiner Heparin induced thrombourtopenia 1-week to Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of burial-transit Due to (or as a consequence of) attending physician for use as the buria Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown 3 Ectopic pregnancy 4☐PregnanI at time of death Day Year 5 Other (specify) the 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Completed 2 X No 1 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Certification: To npatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28b. Time of 28c. Injury at Work? After 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending Injury within 24 hours after death. To the Funeral Director: A investigation 1 ☐ Yes 2 ☐ No 6 Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) asmine Malik M.B. April 15 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 22 South Green Street Battimere Maryland asmine Male 3 Date filed (Month, Day, Year) APR 1 8 32. Registrar's Signature State Registrar

		1	1 - For State Registrar	State of Maryla		artment of H			piene 005	14348
	Physici /Medic		1. Decedent's Name (First, Middle, Last		rret	1		2. Date of Dea Month		3. Time of Death 05 3:22 PM
	Examin		4a. Facility Name (If not institution, give Loas fal Hospic  5. Social Security Number  6. Se	street and number)  e of the L	ake	4b. City, Town, or	Location of Death		4c. County of De	
	Funeral Director			M 20 <b>X</b> F 72	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day 08-13-	1932 HAN	COCK, N.Y.
	e Maryland Be-f show diffied at	Director	10a. State 10b. County MD WICOM		ity, Town or Lo					10d. Inside City Limits 1 Y Yes 2 □ No
	with the a or 2	Dire	10e. Street and Number	IJТ		10f. Zip Code	21804		10g. Citizen of What US	· ·
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Pyglene. Importent: If item 27 is marked other than "natural", or Items 23e or 28e-f show any fujury or other traumatic event, the Madical Examinar must be notified at once.	by Funeral	711 CANVASBACK COT  11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in the Armed Forces?  1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:		Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 ☑ No		pecify Yes or No- Rican, etc.)		merican Indian,
21215-0036	within 72 hou ene. than "natura ne Medical E	Completed	15. Decedent's Edit (Specify only highest grad	ucation	(Give	dent's Usual Occupa kind of work done of DO NOT use retired	during most of won	king	16b. Kind of Busine	
d 2	e filed al Hygi other vent, I	Be Co	17. Father's Name (First, Middle, Last)			COLLEGIC		e (First, Middle,	Maiden Sumame)	COLLANT
Maryland	Menta Menta Marked	ToE	NEIL JOHN TOBIN					E SHAFF		
Mai	nd 2 st ulth and 27 is n r traun		19a. Informant's Name/Relationship (T) CHARLES SHARRETTS	,		-			r, City or Town, State Y • MARYLANI	
altimore,	ges 1 a of Hea If item or othe		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ I	20b.	Place of Dispo	osition (Name of matory or other plac		Date	20c. Location - City	
Ħ	nit. Pagartment ortent: injury o		'4 ☐Donation 5 ☐ Other (Specify, 21. Signature of Euneral Service Licens	MD			,		HURLOCK, N	
Ba	Depa Impo any ir	. 1	Allisa K	Heung					NERAL HOMI SBURY,MARY	L, INC. ZLAND 21804
	Pnysician /Medical Examiner		23a. Part 1. Enter the disease, or comp shock, or heart failure. List enty of Immediate Cause (Final disease or condition resulting in death)	lications that caused the dearne cause on each in  a. Due to (or as a conse	B	ter the mode of dyin	g, such as cardiac		est,	Approximate Interval Between Onset and Death
30,	xecuted and I-transit	i Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a consec.  Due to (or as a consect.						
68760,	ficate be ex physicien is the buria	edica		d	_					
.O. Box	the death certificate y the attending phys ached for use as the	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregr 1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of 9 ☐ Unknown	tal death 3	□Ectopic pregnancy □ Other (specify)			23d. Date of o Month	delivery Day Year
s, P	w requires that the de been signed by the a should be detached f	by	Part II. Other significant conditions co	ntributing to death but not re	sulting in the u	inderlying cause give	en in Part I.	23e. Did to	V. 2	to the cause of death?  Probably 4 □Unknown
of Vital Record	The law ate has b page 2 sl	Completed						24a. Was a autoperfor 1 Tes	sy prior t	
ľ Vit	S S D	o Be	25. Was case referred to medical examiner?  1 Yes 2 No	Hospital: 1 In atient 2[	☐ ER/Outpatie	nt 3 DOA Othe	or.	th (Check only or ome 5 - Resid	ence 6 Other (S	pecify)
ion o	ding After fune	ation: T	27. Manner of Death Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time o	Worl			ow injury occurred	,
Division	in Direct	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At I building, etc. (Spec		reet, factory, office		28f. Location (S City or Tow	treet and Number or n, State)	Rural Route Number,
	4 th	edical	29a. Certifier (Check only one)  Certifying Phylogen Certifying Ph	vsician: To the best of my kr iner: On the basis of examin and manner stated.	nowledge, deat nation and/or in	h occurred at the tin evestigation, in my of	ne, date and place pinion, death occu	and due to the or rred at the time, o	ause(s) and manner late and place, and c	as stated. lue to the cause(s)
)	To the lawithin 2: To the law complet	2	29b. Signature and title of certifier	200 1	D	29c. License			29d. Date signed (Mo	nth, Day, Year)
	1-8		30. Name and address of person who of	ompleted cause of death (Ite		Print)	262/	727		1.12:00-
	Sta	ite	31. Date filed (Month, Day, Year)	32. Pagistrar's Sign	AL 140 nature	SIKE F	NO BOX	155	100/15/	Mes 2/802
	Registi		APR 1 5 20	105 Brane	H A	parte				

			For State Registrar	State of	of Mary		partment of Fertificate of		_		)5	14349
			Decedent's Name (First, Middle	e, Last)	-				2. Date of Dea	eg. No.		3. Time of Death
П	Physicia		Mattie	Lou Shav	J				Month April	L1, 20	Year 05	8:40P M
	/Medic Examin		4a. Facility Name (If not institution	n, give street and nu	ımber)		4b. City, Town, o	or Location of Death		4c. County		
			Southern Mary	Land Hosp	ita1		Clinton			Princ	e Geo	rge
	Funeral		5. Social Security Number	6. Sex 1 ☐ M 21 F		yrs. last birthda	/) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day	Year	Cour	lace (State or Foreign
	Director		577-34-0312 Usual Residence of Decedent	10 M 2KJF	6	30 Yrs.			March 6	, 1925	South	Carolina
	land ow		10a. State 10b. County		10	c. City, Town or	Location				1	0d. Inside City Limits
	Mary I-feh	tor	Maryland Prince	George	F	orestvi	11e					1⊠Yes 2 No
	n 282	Director	10e. Street and Number				10f. Zip Code		1	Og. Citizen of \	What Cour	ntry?
	th wit	aiD	7147 Donnell P.	lace; Uni	t C2		2	0747		United	Stat	es
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Importent: If item 27 is marked other than "neturel", or Itams 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	l by Funerai	11. Marital Status  1 Never Married 2 Mar  3 W Widowed 4 Divorced	If Yes. G	orces? 2⊠No ive	r in U.S. 13	. Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 ☑ No		pecify Yes or No- o Rican, etc.)		e - Americk, White,	
5-0	72 h	etec		it's Education st grade completed	1	(Gi	edent's Usual Occup re kind of work done	during most of wor	king	16b. Kind of B	usiness/In	dustry
121	within noe. .han	Completed by	Elementary/Secondary (0-12)	College (	1-4or 5+)		DO NOT use retire		ant	Federa	1 Gov	ernment
	filed v Hygie ther t	e Co	17. Father's Name (First, Middle,	Last)		Adiii	IIISCIACIV		ne (First, Middle,			CIIMCIIC
an	ld be ental kad c	To B	Albert Philson	n				Bessie	Steward			
Maryland	shou and M s mar		19a. Informant's Name/Relations	ship (Type, Print)		19b. Ma	iling Address (Street	and Number or Ru	ral Route Number	r, City or Town,	State, Zip	Code)
	and 2 salth n 27 l		Thomas J. Shaw	/Son		3914	A-Stoneg	ate Dr.;	Suitland	1, MD.	2074	.6
Baltimore,	of H if iter		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation	3 Removal from	State	cemetery, ci	position (Name of ematory or other pla		1	20c. Location -	-	
ţ,	t. Pag tmen tent:		`4 □Donation 5 □ Other (S		I		oln Cemet					ood, Md.
Bal	Depar Depar Impor any ir		21. Signature of Fundial Pervice	Licensee	le	~	22. Name and Addre	ess of Facility	Pope Func 5538 Mar Forestvi	lboro P lle, MD	ike • 20	747
г			23a. Part1. Enter the disease, o shock, or heart failure. Lis	r complications that only one cause on	caused the	death. Do not e	nter the mode of dyir	ng, such as cardiac	or respiratory arr	est,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	a Co	rona	ry A	tery	1) Iseuse				Onset and Death
	/Medical Examiner		resulting in death)	Due to	(or as a co	onsequence of):						
		70	Sequentially list conditions,	b. — Dua to	for as a sc							
	ited nsit	Examiner	cause. Enter Underlying Cause (Disease or injury	<b>4</b>	(0. 40 4 0.	incode on,						
Ċ,	execu n and ial-tra	Еха	that initiated events resulting in death) Last	c. Due to	(or as a co	onsequence of):						
8760,	cate be executed physician and the burial-transit	dicai		d								
9			IF FEMALE:								-	
.O. Box	that the death certificated by the attending point of the detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		birth 2 [ nant at tim	Fetal death	☐Ectopic pregnance	у		23d. Da	te of delive nth	Day Year
<u>α</u>	requires that the een signed by th hould be detache	y Ph	Part II. Other significant conditi	ons contributing to	leath but n	ot resulting in the	underlying cause giv	en in Part I.	23e. Did to	bacco use cont	ribute to th	e cause of death?
rds,	quires in signe	ed by							1 🗆 Y	es 2□No	3 🔲 Prob	ably 4 Unknown
Record	> 0 0	Completed							24a. Wasa	n 24b.	Vere auto	psy findings available
Re	0 = 0	шо							autops perfori	med? [ c	orior to coi death? I 🗌 Yes	npletion of cause of
Vital	iclen: Th certificate rector, pag	Be C	25. Was case referred to medica examiner?	ıl				26. Place of Dea	th (Check only or	9		
of V	9 v H	To	1 ☐ Yes 2 No		Inpatient	2 ER/Outpat	ent 3 DOA Oth	ner: 4 Nursing H	ome 5 Reside	ence 6 Oth	er (Specif	<i>'</i> )
		ion:	27. Manner of Death 1 Natural 5 ☐ Pendi	ig .	of Injury oth, Day Ye	ear) 28b. Time Injury	Wor		28d. Describe ho	ow injury occurr	ed	
isic	Attending or death. sctor: After by the fune	icat	3 ☐ Suicide 6 ☐ Could		o of Injune	At home farm	M 1 []	Yes 2 □ No	28f. Location (Si	treet and Numb	or or Pum	/ Pouto Number
Division	l or Atten after deat Director:	ertification;	4 ☐ Homicide determ	nined 200. Flac build	ling, etc. (5	Specify)	street, factory, office		City or Town		er or riura	r Houle Maniber,
	To the Hospitel or Atten within 24 hours after deat To the Funerel Director: completely filled in by the	calC	29a. Certifier Certifyi	ng Physiciaju: To th	e best of m	ny knowledge, de	ath occurred at the tir	me, date and place	, and due to the c	ause(s) and ma	nner as si	ated.
	the Ho hin 24 h the Fu npletely	edi	(Check only /2 Medical one)	Examiner:/On the I	nasis of example of example of the contract of	amination and/or	investigation, in my o	pinion, death occu	rred at the time, d	ate and place,	and due to	the cause(s)
	To the within To the comple	Ž	29b. Signature and title of dertific	or/ //			29c. Licens	se number	2	9d. Date signed		-
Δ			In Me	Mel			1)00	59428		4-10	1-0	5
2	(15)		30 Name and address of person	who completed cau	se of death	(Item 23a) (Typ	Print)	t Rd	2073	5		
	Sta		31. Date filed (Month, Day, Year		Registrar's	Signature	-					
	Registr	ar	APR 14	2005	we	15 to	refer					/

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** LILLIAN ELIZABETH SMITH 2005 10 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner WICSMICS YenInsula Salisburg KIDIONAI Medicai If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 1913 9. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday **Funeral** Min. Days Hours 1 □ M 2 🖾 F Director 228-40-3655 91 November GEORGÍA Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location If Item 27 is marked other than "natural", or Items 23a or 28e-f show or other treumatic event, the Madical Examinar must be notified at 10d. Inside City Limits DC Director 1X Yes 2 No WASHINGTON, DC 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 108 RIGGS ROAD S.E. 20019 U.S.A. permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiane. Importent: If Item 27 is marked other than "natural", or Items 23a any Injury or other treumatic event, the Mudical Externing Process. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: Specify: BLACK þ 3 X Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 9th EVANGELIST PRIVATE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) HENRY LEWIS GEORGE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) L. MCKINNEY/GOD DAUGHTER RITA 3008 ADAMS STREET N.E. WASHINGTON, DC 20018 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) HARMONY CEMETERY 4/18/05 LANDOVER, MARYLAND 21. Signatur > Euri ral Pervice Licantee 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 7474 LANDOVER RD. LANDOVER, MARYLAND 20785 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) PNE UMOUIA Priysician 3days /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner been signed by the attending physician and should be detached for use as the burial-transit certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by SCUD 1 Yes 2 No 3 Probably 4 Donknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? cartificate 1 ☐ Yes 2/2 No 1 ☐ Yes 2 ☐ No To the Hospitel or Attending Physician: within 24 hours after death.

To the Funerel Director: After this cartiflos completely filled in by the funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital 1 Yes 2 No 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) woulder-Mach D32014 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MODUTER 106 WITTOUR ST SOY B SalisBury and 21804 MAMESM 31. Date filed (Month, Day, Year) . Registrar's Signature.

DHMH 17 Rev 1/200

State

Registrar

APR 1 4 2005

228-40-365

IIIA SMIK

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Registrar/Amend Item #20b Per FH G848 Ochulidate dilDeath Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month Year APRIL 5:23 SANDERS 2005 ROGERS /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 10116 CAMPUS WAY SOUTH # PRINCE GEORGES 101 LARGO If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1₩ M 2□ F Director 61 July 27 1943 NORTH CAROLINA 246-64-0868 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County or 28a-f show 10d. Inside City Limits the Medical Examiner must be notified at Director 1 Yes 2 No LARGO MD PRINCE GEORGE'S 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 238 10116 CAMPUS WAY SOUTH # 101 20774 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. "naturel", or Items 11. Marital Status e filed within 72 hours efter al Hygiene. other than "naturel", or Ite 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☒ No Specify: þ 3 Widowed 4 Divorced BLACK Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) 2YRS Elementary/Secondary (0-12) GOVERNMENT Administer Assistant permit. Pages 1 and 2 should be filed v Depertment of Health and Mental Hygie Importent: If Item 27 is marked other I any Injury or other traumatic event. Ith one. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) MINA BRANCH ROBERT LEE SANDERS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 19a. Informant's Name/Relationship (Type, Print) 10116 CAMPUS WAY S.# 101 LARGO, MARYLAND 20774 DAMON SANDERS/SON 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 4/18/2005 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State ' 4 ☐ Donation 5 ☐ Other (Specify) Riverdale Crematory Riverdale,Maryland 21. Signat no of Funeral S 22. Name and Address of Facility J. B. Jenkins Funeral Home 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 Parts Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Vantrica 0 /Medical Due to (or as a consequence of) Examiner congestive 140. fany, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as # consequence of): Examine physician and s the burial-transit certificate be executed resulting in death) Last Due to (or as a consequence of) Physician/Medical anemia IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☒ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) per the 9 Unknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 2 No 1 Yes Hospitel or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No filled in by the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: After 1 Natural 2 Accident 5 Pending investigation death. 1 ☐ Yes 2 ☐ No s efter death 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours of To the Funeral 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D14063 April 13, 2005 elotra 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar David Boetcher M.D.

APR 1 4 2005

31. Date filed (Month, Day, Year)

Baltimore, Maryland 21215-0036

P.O. Box 68760,

Division of Vital Records,

14300 Gallant Fox Ln. # 118 Bowie, Maryland 20715

	*2		State of Maryland / Depart 1- State Registrar amend item #4/per fh/wchd/498#	ment of Health and N										
	9		1. Decedent's Name (First, Middle, Last)	194 CEWI Deali	2. Date of Death		3. Time of Death							
	Physicia /Medic		Charles C. Simpson		April	11 2005	0430 JM							
	Examin			b. City, Town, or Location of Death		4c. County of Death								
	Funeral			SUI IS BUILD Under 1 Year If Under 244ris.	8. Date of Birth (Month, Day, )		place (State or Foreign							
	Director		800-241-3371 1IXM 2□ F 88 Yrs. M	lonths Days Hours Min.	(Month, Day, ) 12/20/1		ington,DC							
	and w		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location	on			10d. Inside City Limits							
	Maryi Haho	to	Maryland Wicomico Salisbur	У			1. Yes 2 □ No							
	with the 3e or 28a	I Direc	10e. Street and Number 411 Somerset Ave.	10f. Zip Code 21801	100	g. Citizen of What Cou USA	ntry?							
980	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. If Health and Mental Hygiene. Item 27 Is marked other then "naturel", or Items 23e or 28a-f show other treumatic event, it we Medical Evan instrnut be notified at	by Funeral Director	Armed Forces? If Ye 1 □ Never Married 2 □ Married 1 □ X Yes 2 □ No 1 2 → N	s Decedent of Hispanic Origin? (Spas, specify Cuban, Mexican, Puerto Yes 2 A No Specify:	pecify Yes or No- Rican, etc.)	14. Race - Ameri Black, White, Specify: W								
2-0	72 hou	eted	15. Decedent's Education 16a. Decedent	t's Usual Occupation d of work done during most of work	sina 16	6b. Kind of Business/In	ndustry							
21215-0036	within ene. then "	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	NOT use retired)	9	Insurance								
	filed with Hygiene. other thei		17. Father's Name (First, Middle, Last)	nce Adjuster  18. Mother's Nam	e (First, Middle, Ma									
/lan	Mental Mental Marked o	To Be	Arthur Cole Simpson	Gertrud	de Nevin									
Maryland	2 should and Men Is marke	D		Address (Street and Number or Run										
	s 1 and 2 of Health item 27		20a Method of Disposition 20b. Place of Disposition	enokin Dr., Apt.		Oc. Location - City or To								
altimore,	Pages nent of thint: If its iry or o		1 □ Burial 2 🕱 Cremation 3 □ Removal from State  '4 □ Donation 5 □ Other (Specify)  Commetery, crematic			Salisbury,								
Balti	permit. Pages Department of Importent: If it any injury or o		the state of the s	ame and Address of Facility Lloway Funeral H	Iome Profe	essional As	ssociation							
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter t shock, or heart failure. List only one cause on each line.				Approximate Interval Between							
		Onset and Death												
	/Medical Examiner		resulting in death)  Due to (or as a consequence of):											
	D ==	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	1,700/										
	ficate be executed physician and sthe burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):											
68760,	be ex sician burial	alE	Due to (or as a consequence of).											
_	tificate ig phys as the	ledical	0.											
O. Box	The law requires that the death certific Ite has been signed by the atlending p bage 2 should be detached for use as i	Physician/M		topic pregnancy ther (specify)		23d. Date of deliving Month	ery Day Year							
Δ.	luires that the de n signed by the a lid be detached f	þ	Part II. Other significant conditions contributing to death but not resulting in the under	rlying cause given in Part I.		acco use contribute to t	he cause of death?							
Records,	The law requir te has been si age 2 should l	Completed			24a. Was an autopsy perform	eg/? death?	opsy findings available impletion of cause of							
Vital		BeC	25. Was case referred to medical examiner?		th (Check only one,									
of \	Physicien: this certific ral director,	2	1  Yes 2  No  Hospital: 1  Inpatient 2  ER/Outpatient 27. Manger of Death  28a. Date of Injury 28b. Time of		ome 5 Residen	nce 6 Other (Special								
ion	Attending F r death. sctor: After by the funer	tion	1 ♥ Natural 5 □ Pending (Month, Day Year) 2 □ Accident investigation	28c. Injury at Work?  M 1 Yes 2 No	200. DOSCIDO NON	v signity occurred	Rehow							
Division	ol or Attendi after death. I Director: A d in by the fu	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street building, etc. (Specify)	factory, office	28f. Location (Stre City or Town,	eet and Number or Rura State)	al Route Number,							
	To the Hospitel or Attent within 24 hours after deatl To the Funerel Director: completely filled in by the	Medical C	29a. Certifier  (Check only one)  1 Certifying Physicien: To the best of my knowledge, death or control on the basis of examination and/or invessed and manner stated.	curred at the time, date and place, tigation, in my opinion, death occur	and due to the cau red at the time, dat	use(s) and manner as s te and place, and due t	stated. o the cause(s)							
	To the within To the comp	ž	29b. Signature and title of certifier	29c. License number	290	d. Date signed (Month,								
	18.00		Indi water	0057359	L.	tpril 11/ 200	05							
`	170		30. Name and address of person who completed cause of death (Item 23a) (Type, Pri	,	SBURY M	10 21804								
•	Sta Registr		31. Date filed (Month, Day, Year)  APR 1 3 2005  32 Registrar's Signature  April 1 3 2005	li										

		1 - For State Registrar	State of Mary		Pertificate of		, ,	eg. No <sub>to</sub>			
Physic /Medi		Decedent's Name (First, Middle, Last  KEVIN	MARK			TESTOFF	2. Date of Dea Month APRIL	Day Year	3 Time of Death		
Exami Funeral Director	ner	4a. Facility Name (If not institution, give THE JOHNS HOPKI 5. Social Security Number 215 68 9980	NS HOS	EPITAL nyrs. last birtho Yr	day) If Under 1 Year	M D R C  If Under 24 Hrs  Hours Min.	CITU  8. Date of Birth	4c. County of Dea Non 1960 9. Bin 1960 Wa	ith		
land bw		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location									
death with the Maryland ms 23a or 28a-f ehow r nust be natified	tor	MD Howard		Ellicot	t City				1 ☐ Yes 2 ☐ <b>Ñ</b> lo		
ith the	Director	10e. Street and Number			10f. Zip Code		1		. Citizen of What Country?		
sath w		8202 Elko Drive	12. Was Decedent Eve	rinllC	210		Consider Van en ble	United St			
Tet est	by Funerai	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	Amed Forces? 1 ☐ Yes 2 ☑No If Yes, Give Year or Dates:	1110.3.	<ol> <li>Was Decedent of If Yes, specify Cub</li> <li>Yes 2X No</li> </ol>		to Rican, etc.)	14. Race - Am Black, Whi			
be filed within 72 hours at lat Hygiene. d other than "neturel", or event, the Wedcal Exam	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	cation le completed) College (1-4or 5+)	(6	ecedent's Usual Occu Give kind of work done ife. DO NOT use retire	during most of wo	orking	16b. Kind of Business			
		17. Father's Name (First, Middle, Last)	4	Fir	nancial Ana		me (First, Middle,	Defense			
rand	To Be	Arthur Testoff					Pecoraro	walden Suniame)			
Maryiand d 2 should be file th and Mental Hy i7 is marked oth traumatic event	F	19a. Informant's Name/Relationship (T)	/pe, Print)	19b. N	Mailing Address (Stree	and Number or R	ural Route Number	r, City or Town, State,	City or Town, State, Zip Code)		
C = 64 F		Susan E. Testoff/W				ive Ellic		, MD 21043			
MOTE, Pages 1 ar		20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ F	Removal from State	cemetery,	Disposition (Name of crematory or other pla	· 1		20c. Location - City of			
		<ul> <li>4 □ Donation 5 □ Other (Specify,</li> <li>21. Signature of Funeral Service Licens</li> </ul>			Lawn Cemete	- ,	.6–2005	Marriotts			
Dennit. Departitimports any inju		Dem Collin	o titthe	101044	4112 01d (	olimbia	rry H. W. Pike Ell	itzke's Fa icott City	mily FH Inc.		
Pnysician	9.	23a. Part1. Enter the disease, or comp shock, or heart failure. List only o Immediate Cause (Final		e death. Do no	t enter the mode of dy	ng, such as cardia	c or respiratory arr	est,	Approximate Interval Between Onset and Death		
/Medical Examiner		disease or condition resulting in death)	Due to (or as a co		):	BOLUS			I WEEK		
BOX 68/60, asth certificate be executed attending physician and for use as the burial-transit	edicai Examiner	Sequentially its containous,  I any, heading to him-ediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):									
DOX bath cer attendin for use	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of p 1 □ Live birth 2 □ 4 □ Pregnant at tim 9 □ Unknown	Fetal death	3 ☐ Ectopic pregnand 5 ☐ Other (specify) _	·y	-0.	23d. Date of de Month	elivery Day Year		
cords, F.C. wrequires that the deben signed by the should be detached	by	Part II. Other significant conditions co		e contribute to the cause of death?							
II HECOFIGS, The law requires the last been signed page 2 should be of	Completed						24a. Was a autops perfon	sy prior to	utopsy findings available completion of cause of s 22(No		
Or VIIai r Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	. In a mit at				ath (Check only or				
Phys this	- L	1 Yes 2 No 27. Manner of Death	Hospital: 1 Unpatient 28a. Date of Injury	2 ER/Outp	alibrit 3 DOA			ence 6 Other (Special Control of the	ecify)		
Attending I r death. sctor: After by the funer	atlon	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Ye	ear) Inju	ury Wo	ork? ]Yes 2⊟No	256. 5666.56	ow injury occurred			
LIVISION of or Attending s after death. In Director: After	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc. (5		n, street, factory, office		28f. Location (Si City or Town	(Street and Number or Rural Route Number, own, State)			
UIVI  To the Hospitel or Al within 24 hours after of To the Funerel Directompletely filled in by	edical C	29a. Certifier 1 Certifying Phy (Check only one) 2 Medicel Exem	rsicien: To the best of miner: On the basis of exand manner stated	amination and/	death occurred at the to or investigation, in my	ime, date and plac opinion, death occ	e, and due to the c urred at the time, d	ause(s) and manner a ate and place, and du	s stated. e to the cause(s)		
To the within 2 To the complet	M	29b. Signature and title of certifier	2	4		se number		9d. Date signed (Mon			
		Mayama	omeloted acres of the	M , D		7600	1	JARIL 12 2	005		
(p)		30. Name and address of person who of DIRUPAMA MIT	KIRI, GO	0 N. L		REET, B	ALTIMO	E, MD-	21287.		
Si	ate	31. Date filed (Month, Day, Year)	32. A gistrar's	Signature	1 3						

ental	Hygiene	n	Ο	- La
	and the	U	11	. )

3. Time of Death

			1 - State Registrar			Certificat	te of Death		Reg. No.	U5	14355			
	Di		1. Decedent's Name (First, Middle, L	ast)				2. Date of D	eath		3. Time of Death			
	Physici /Medio		MARTHA ANN	THOMAS				APRIL	Day <b>G</b>	2005	1540			
	Examir		4a. Facility Name (If not institution, g				, Town, or Location of I			nty of Death				
			the MEMORIAL				STON		1	TALBOT				
П	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months, Days Hours Min. (Month, Day, Year) 9. Bi											
	Director		Usual Residence of Decedent  1 M 3 F 72 Yrs. Months Days Hours Min. (Month, Day, Year) Country)  Usual Residence of Decedent											
	land ow		10a. State 10b. County 10c. City, Town or Location											
	Mary f sh	to	MD Caro	line			Preston				10d. Inside City Limit 1 ☐ Yes 2 🙀 N			
	r 28e	Director	10e. Street and Number			10f. Zig	o Code		10g. Citizen o	t What Cour	ntry?			
	h with	O E	109 Backlandi	ng Road			21655		Unite		•			
	death	Funerai	11. Marital Status	12. Was Decedent E	ver in U.S.	13. Was Dece	dent of Hispanic Origin cify Cuban, Mexican, F	? (Specify Yes or N	o- 14. R	ace - Americ	can Indian,			
ဖွ	or Ite	F	1 Never Married 2 Married	Armed Forces?  1 Tyes 2 X No	0			uerto Rican, etc.)	В	lack, White,				
8	ours Fral',	d by	3 Widowed 4 Divorced	Year or Dates:		1 🗆 Yes	2 No Specify:		Spec	ify: Wh	ite			
Baltimore, Maryland 21215-0036	ges 1 and 2 should be filed within 72 hours atter death with the Maryland to f Health and Mental Hyglene.  If item 27 is marked other then "natural", or items 23a or 28e-f show or other traumatic event, it is Medical Expriner must be notified at	Completed	15. Decedent's l (Specify only highest g	Education rade completed)	16a	Decedent's Usu (Give kind of wo	nk done durina most o	workina	16b. Kind of	Business/Inc	dustry			
121	vithin ne. hen	mpi	Elementary/Secondary (0-12)	College (1-4or 5+	+)	life. DO NOT u	se retired)	<b>.</b>						
2	lled v dygie har t	ပိ	12 17. Father's Name (First, Middle, Las			но	memaker			Home				
anc	12 should be filed within h and Mental Hygiene. 7 Is marked other then "Ireumatic event, the Med	Be	William Arthu	,				Name (First, Middle		ите)				
Ž	hould d Me mark mark	10	19a. Informant's Name/Relationship		100			ie Mae W						
Ma	d2 s th an 7 Is r traur		·				(Street and Number of							
ė,	1 and Health am 27 other tr		Donald E. Thom  20a. Method of Disposition	as/Spouse		J9 Back of Disposition (Nar	landing l	Road, Pr	eston,	MD	21655			
õ	nt of nt of :: If it		1X Burial 2 □ Cremation 3		cemete	ry, crematory or o	other place)	9/2005	20c. Location	,	,			
퍒	it. Purtue		*4 □ Donation 5 □ Other (Spec 21. Signature of Funeral Service Lice		Jr. (	Order C	CIII	9/2003	Prest	on, I	Maryland			
Ba	permit. Pages 1 and 2 Department of Health s Important: If Itam 27 It any injury or other tra		21. Signature di Puneral Service Lici	ensee			nd Address of Facility	Federa	1sburg	, Ma	ryland			
			23a. Part1. Enter the disease, or con	mplications that caused t	the death. Do		tom Funer							
	ę		SHOCK, OF Heart failure. List one	y one cause on each line	ene death. Do	not enter the mod	e of dying, such as car	diac or respiratory a	arrest,		Approximate Interval Between Onset and Death			
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Cerebro	Vascul	an ace	dent				Onset and Death			
	Examiner			Due to (or as a	consequence	of):								
		e	Faquentiany list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a	consequence	in Stern	0316				<del></del>			
	t insit	Examine	Cause (Disease or injury	4321	CI A	MALE.								
_^	certificate be executed oding physician and use as the burial-transit	Xal	that initiated events resulting in death) Last	devents										
292	siciar buri	ai		Harry	holes	Marsh								
68760,	ficate g phy is the	edicai			20,010	- CMIC								
XO		2	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of					234 0	ate of delive	in/			
m.	death s atte	icia	in the past 12 months?	1⊡Live birth 2 4⊡Pregnant at ti	Fetal death	3 ☐Ectopic pr 5 ☐ Other (sp				ate of deliver lonth	Day Year			
P.O.	t the by the ache	Physicia	9 Unknown	9□ Unknown										
T.	The law requires that the death te has been signed by the atter age 2 should be detached for u	by P	Part II. Other significant conditions	contributing to death but	not resulting is	n the underlying c	ause given in Part I.	23e. Did 1	tobacco use cor	ntribute to th	e cause of death?			
rds	w require been sig should b	ed t	Hypertersi	M)				1	Yes 2 □ No	3 🗆 Proba	ably 4 🔯 Unknown			
00	s bee	ojet	Cocaca do	en disper				24a. Was	an 24h	Were autor	osy findings available			
Re	stcian: The tar certificate has rector, page 2	ompieted	Color on of 11	9	<b>7</b>			auto	psy ormed?	prior to con death?	npletion of cause of			
tal		e C	25. Was case referred to medical				ac Black	1 ☐ Yes	2 No	1 Yes	2 No			
Division of Vital Records,	yslci. s cer direct	OB	examiner? 1 Yes 2 No	Hospital:	t 2□ER/Ou	Itpatient 3 DO	000	Death (Check only o		hos /6				
0	g Ph er thi eral c	L	27. Manner of Death	28a. Date of Injury	28b. 1		8c. Injury at Work?	g Home 5 Resi	dence 6 ∐Ot how injury occu		")			
0	nding ath. r: Aft	atio	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day	Year) I	njury M	Work? 1 ☐ Yes 2 ☐ No							
Vis.	Atte	iffe	3 ☐ Suicide 6 ☐ Could not l 4 ☐ Homicide determined	286. Place of Injur	y - At home, fa	m, street, factory	, office	28f. Location (	Street and Num	ber or Rural	Route Number,			
	s afte	Certification:	4 🗀 Hornicide	building, etc.	(Specify)			City or To	wn, State)					
	bours hours unare y fille		29a. Certifier 1 Certifying P	hysicien: To the best of	my knowledge	e, death occurred	at the time, date and pl	ace, and due to the	cause(s) and m	anner as str	ated.			
	To the Hospital or Attending Physician: within 24 hours after death. To the Funaral Director: After this certifica completely filled in by the funeral director;	edicai	(Check only 2 Medical Exa	miner: On the basis of e and manner state	examination an	d/or investigation,	in my opinion, death o	ccurred at the time,	date and place,	and due to	the cause(s)			
	To t To tl	Σ	29b. Signature and title of certifier				. License number		29d. Date signe	ed (Month, E	Day, Year)			
•			Hourt	n///	20	D	005976	62	ANT	1061	05			
		-		~ /					1.0	1001	~ /			

ORIGINAL

32. Registrar's Signature

Easton/MD 21601

Harde Sorofi 31. Date filed (Month, Day, Year)

State Registrar DHMH 17 Rev 1/2001

			1 - For State Registrar		of Marylan	id / Dep		t of He	ealth a	and M	•		200	E.	11.050	
			Decedent's Name (First, Midd	lle, Last)	<del></del>		- Inout				2. Date of De	- "	<u> U U</u>	J	3. Time of Death	
	Physici		Viola	B. Tob	inc						Month April	10 Day	, 2005 \	Yeer	8:49 P M	
	/Medio Examir		4a. Facility Name (If not institution				4b. City.	Town, or	Location of		тргтт	T.	County of	Death	0.49 1	
	LXaiiii	ici	Prince George					ver1					Prince george's			
	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	If Under	1 Year	If Under		8. Date of Bi (Month, D				lace (State or Foreign	
	Director		578-48-2122 Usual Residence of Decedent	1□M 2⊠F	74	Yrs.	Months	Days	Hours	Min.	Novemb	er 1			inia	
	show		10a. State 10b. Count	у	10c. Cit	y, Town or L	ocation			-			10d. Inside City L			
	Marie S	ţo	MD Prince	e George's		Landov	er								1X Yes 2 No	
	or 28	ire	10e. Street and Number				10f. Zip					10g. Cit	izen of Wh	at Coun	itry?	
	ours after death with the Maryla raf', or Itams 23a or 28a-f shov Examiner must be notified at	Funeral Director	900 Finch Dri	ve				2078	35			U.	S.A.			
	ams erms	Inel	11. Marital Status	12. Was Dec	edent Ever in U	.S. 13.	Was Deced	lent of His	spanic Ori	gin? (Spe	cify Yes or N Rican, etc.)	0-	14. Race -	- Americ White,		
36	or It		1 Never Married 2 Ma	II Yes Gi	2 ⊠ No ve	1	1□Yes :						Specify:			
Ö	ural',	Completed by	3 ☑ Widowed 4 □ Divorce		ates:							, 1		Blac		
5	"nat	iete		nt's Education es <i>t grade completed)</i>		16a. Dece	dent's Usua kind of wor DO NOT us	il Occupa k done di	tion <i>uring m</i> os	t of workir	ng	16b. K	ind of Busi	ness/inc	dustry	
12	withir ane. than	m d	Elementary/Secondary (0-12)	College (	1-4or 5+)			e reureu)				D.	rivat			
d 2	filed within 72 hours after death with the Maryland Hygiene. other than "naturel", or Itams 23a or 28a-1 show ant, the Madical Examiner must be notified at		12th 17. Father's Name (First, Middle	. Last)		wai	tress		18. Mothe	er's Name	(First, Middle					
an	d be antal tad o	Be C	Samuel Piatt								Harri		<i></i>			
Maryland 21215-0036	2 should be and Mental is markad c	2	19a. Informant's Name/Relation			19b Maili	na Address	(Street a			l Route Numb		r Town Si	tate Zin	Code)	
S	d 2 s th ar 27 is trau		Antoine Piatt								er, Ma			_	0000)	
ē,	1 and 2 Health tam 27		20a. Method of Disposition	•	20b. F	Place of Dispo	osition (Nan	ne of		, D	ate	20c. Lo	ocation - Ci	ity or To	wn, State	
0	Pages nent of I int: If its iry or o		1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Qther (		State	semetery, cre		ther place		4/16/	05				aryland	
Baltimore,			21. Signature of Egneral Service		FL	. Linc	2. Name an	d Address			B. Je			-		
Ba	permit. Departn Imports any Inju		OSTAT.	N							Landov					
			23a. Part1. Enter the disease, of	or complications that	caused the deat											
			snock, or neart failure. Lis	t only one cause on	each line.			, ,			,				Approximate Interval Between Onset and Death	
	Physician /Medical		disease or condition resulting in death)	a	or as a conseq	1 1 1 1 1								_		
н	Examiner			Due to	350 800		Tery		Dis							
		ē	Sequentially list conditions, if any, leading to immediate	b. Due to	(or as a conseq		161		1713	ease	-			-		
	be executed sician and burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events	<b>S</b>	11Per	tensi	ah -									
Ć,	exec n an	Еха	resulting in death) Last		(or as a conseq		01									
760,	w ~ w	cai		d												
9	leath certificat attending phy ifor use as th			_												
Вох	h cert andin use	Physician/Med	IF FEMALE: 23b. Was decedent pregnant		tcome of pregna		Testania as						23d. Date	of delive	гу	
	deatl e atte	icia	in the past 12 months?	4□Preg	nant at time of d		□Ectopic pr □ Other (sp						Month	1	Day Year	
O.	at the de by the a tached t	hys	9 🗆 Unknown	9L Unkr	own											
٦,	res tha igned I be det	ру Р	Part II. Other significant condit	ions contributing to o	eath but not res	ulting in the u	inderlying c	ause givei	n in Part I.		23e. Did	tobacco u	se contrib	ute to th	e cause of death?	
rd	w require been sig should b										1 🗆	Yes 2	_No 3	Proba	ably H Unknown	
Records,	aw requisite shoulk	Completed									24a. Was		24b. We	ere autor	osy findings available	
Ä	The lay	mo										ormed?	dea	ath?	npletion of cause of 2 No	
Vital		Be C	25. Was case referred to medic	al					26. Place	of Death	(Check only			, 103	20140	
<b>&gt;</b>	d in	To E	examiner?	Hospital:	Inpatient 2	ER/Outpatie	nt 3 DO	Other			ne 5□Res		6 □Other	(Specify	•)	
J of	ding Pth h. After th funeral		27. Manner of Death	28a. Date	of Injury	28b. Time o	of 2	8c. Injury	at		8d. Describe					
Ö	uttandin death. ctor: Af y the fur	atic	O JENatural 5 □ Pending (Month, Day Year) Injury Work? 2 □ Accident investigation M 1 □ Yes 2 □ No													
Division	l or Attano after death Diractor: I in by the	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide deten	mined 288. Place	of Injury - At ho	ome, farm, st	reet, factory	, office		2		(Street an		or Rural	Route Number,	
	talors aft	Cer								OI.			,			
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	cai	29a. Certifier Certifyi	ing Physician: To the L I Examiner: On the b	e best of my kno	wiedge, deat	h occurred	at the time	e, date an	d place, a	nd due to the	cause(s)	and mann	ier as sta	ated.	
	tha Hain 24	Medicai	Uney	and mar	ner stated.											
	To tha within To tha comple	2	29b. Signature and title of certifi		1			License		2			e signed (			
0	5		11. Sarr	arazi M	ما ل		\	74,	804			7	/13/	05		
1	-(6)		30. Name and address of person	who completed cau	se of death (Item	n 23a) (Type,	Print)	1		٨	1 1	1				
			1 /1 1	Hunover	Registrar's Signa	(way	Gr	eepe	1)		lury	ind.				
	Sta		31. Date filed (Month, Day, Year APR 1 4	nns C	Registrar's Signa	ature										
	Regist	rai	VIII T # (	POS	W A	A CONTRACTOR OF THE PARTY OF TH										

Robert Boone Tunney Jr Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 05-02503 RpD State of Maryland / Department of Health and Mental Hygiene For State Registral amend item #10c/per fh/wchd/4-75/1631-195 Death Rag. No. 1 Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death Day 2005 **Physician** April 9, Robert Tunney Jr. 2149 P Roone /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Salisbury Wicomico Route 13 @ Truitt Street 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Days 1**X** M 2□ F Hours Min. 60 Director 219-44-7872 6/26/1944 Maryland Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits f Heelth and Mental Hygiene. Item 27 is marked other than "natural", or Items 23a or 28a-1 show other traumatic event, the Medical Examplar must be notified at Salisbury Salo Director 27651 Riverside Dr., Extd. 1 ☐ Yes 2 ☑ No Maryland Wicomico 10e. Street and Number 10g, Citizen of What Country? With 27651 Riverside Dr., Extd. 21801 USA Completed by Funeral deeth 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after inent of Heelth and Mental Hygiene. Int: if item 27 is marked other then "natural", or ite 1 XYes 2 No
If Yes, Give
Year or Dates: Marines 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2 X No Specify: Specify: white 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Program Director Mental Health Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Robert Boone Tunney Sr. Marjorie Kreuzer 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27651 Riverside Dr Extd., Salisbury MD 21801 Nancy Ellen Tunney/wife 20a. Method of Disposition 20b. Place of Disposition (Name of cametery, crematory or other place) 20c. Location - City or Town, State 0=0 1 Surial 2 Cremation 3 Removal from State permit. Page Department of Important: If any Injury or once. 4/14/05 Allen, MD ¹ 4 □ Donation 5 □ Other (Specify) Allen Cemetery 22. Name and Address of Facility
Holloway Funeral Home Professional Association
501 Snow Hill Rd., Salisbury, MD 21804 21. Signature Hamila Service Licensee 23a. Parl. Enter the disease, or complications that caused in speck, or heart failure. List only one cause on each line. Immediate Cause (Final death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between Onset and Death Muries Priysician Due to (or as a const uence of): disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examiner The law requires that the death certificete be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Be Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy jo in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) P.0. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

12 Yes 2 \sum No 24a. Was an page 2 s autopsy 1 Yes 2 No Division of Vital Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Other: 4 Nursing Home 5 Residence 6 Nother (Specify) at scene Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To Yes 2 No 28a. Date of Injury (Month, Day Year) 4-9-05 28c. Injury at Work? 27. Manner of Death 28b. Time of Describe how injury occurred Hospital or Attending Injury 1 Natural 5 Pending ric. death. investigation 0416 2 Accident vehicle 3 after death Director: 6 Could not be determined n 24 hours after de ne Funeral Directo stetely filled in by th 3 Suicide tion (Street and Number or Rural Route Number, 1 Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mander as stated. Medicai within 24 ho

To the Function

completely f 2 XMedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b Signature and title of certifier 29d. Date signed (Month, Day, Year) OCME April 10, 2005

1/1/02

Registrar

31. Date filed (Month, Day, Year)
APR 1 3 2005

30. Name and address of person who completed cause of death (Hem 23a) (Type, Print)

32. Begistrar's Signature

32. Begistrar's Signature

DO5 Straw & Spark

111 Penn Street

Baltimore, Maryland 21201

			1 - State Registrar	State of	Marylar				ealth a Death	and Me	ental Hy	giene	0005	11.	320
	Dhysis		1. Decedent's Name (First, Middle, Last)							2. Date of De		1 3.		of Death	
	Physici /Medi		Theodore	Vaugh					pril	10	2005	4:07	Рм		
	Examir	er	4a. Facility Name (If not institution, give						Location o	of Death			County of Deat		
	Funeral		Prince George's  5. Social Security Number 6. Secur			last birthday)	Une If Unde	verly	If Under :	24 Hrs.	8. Date of Bir		rince G	eorge '	
ı	Director			M 2□F	65	Yrs.	Months	Days	Hours	Min.	(Month, Da Sept	v. Year)	1939	D.C.	or r oronger
	D s		Usual Residence of Decedent  10a. State 10b. County		100 6	h. Tour out									
	fanyia shor	5										10d. Inside C	City Limits		
	the A	Director	10e. Street and Number				10f. Zip					10a Citiz	zen of What Co		
	3a or	0	3009 16th Street, N.E					20018					U.S.	, .	
	within 72 hours after death with the Maryland ene. than "natural", or items 23s or 28s-f show he Madical Examinet must be notified at	Funeral	11. Marital Status	12. Was Decede Armed Force			Was Dece	dent of Hi	spanic Orig	gin? (Spec	ify Yes or No	>- 1	14. Race - Ame		
36	or ite	by Fu	1 Never Married 2 Married	1 ☐ Yes 2 If Yes, Give	<b>∑</b> ] No		1 ☐ Yes		Specify:	, ruento n	ican, etc.)		Black, White Specify: Bla	_	
Ö	"natural", or	q pa	3 Widowed 4 Divorced	Year or Date	9S:	16a. Dece									
15	n "na	Completed	(Specify only highest grade	completed)		(Give		rk done d	lurina most	of working	g	IOD. KI	nd of Business/I	ngustry	
212	illed withir Hygiene. other then	E	Elementary/Secondary (0-12)	College (1-4	or 5+)	Store	Manag	er				Ref	tailer/Au	tamotive	<b>غ</b>
р	be filed within 72 ho ital Hygiene. d other than "natur event, the Modical	Bec	17. Father's Name (First, Middle, Last)						18. Mothe	r's Name	(First, Middle	, Maiden .	Sumame)		
yla		ပ္	Ezachea Vaughn								Lowery				
Mar	nd 2 sho lth and 27 is mu		19a. Informant's Name/Relationship (Ty)  Funice Vauchn-Spouse	pe, Print)									Town, State, Z	ip Code)	
Baltimore, Maryland 21215-0036	s 1 and 2 should f Health and Mer ttem 27 is marke other treumatic		20a. Method of Disposition		20b. F	Place of Dispo	sition (Na	ne of	1	Da	E., WI		cation - City or 1	own State	
100	Pages nent of int: if it		1 ☐ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from St	ate (	cemetery, crei	natory or c	ther place	. !	16.05			,		
altin	그 된 본 분		21. Signature of Funeral Service License	90	паш	mony Men	Name ar	PACK nd Addres	; 4 s of Facility	–16–05			sville, 1 c. Funera		ina
ä	Depermine Depermine Impo		Reginald	Ei Co	Olie					ш.	20018	ASSU	. ruleta	r mie r	IC.
			23a. Part1. Enter the disease, or compli shock, or heart failure. List only or	cations that cau	sed the deat							rrest,		Approxima Interval Be	
	Physician		Immediate Cause (Final disease or condition	Intrac	vania	1 hem	Arhor	e						Onset and	Death
	/Medical Examiner		resulting in death)  Due to (or as a consequence of):  Hyperten( On												
		er	Sequentially list conditions, if any, leading to immediate		as a consec										
	uted d ansit	Examiner	Cause (Disease or injury			,									
o,	exec en an rial-tr	Exa	resulting in death) Last		as a consec	juence of):									
8760,	The law requires that the death certificate be executed at the seen signed by the attending physician and bage 2 should be detached for use as the burial-transit	dicai		l											
9	entific ding p	Mec	IF FEMALE:	0 - 16											
Box	eath certific attending p	Physician/Me	in the past 12 months?	3c. If yes, outco 1□Live birti 4□Pregnar	n 2∐Feta	aldeath 3□	Ectopic pr					2:	<ol><li>3d. Date of deliver</li><li>Month</li></ol>	-	Year
o.	at the de by the tached	ysic	1 Yes 2 No 9 Unknown	9☐ Unknow		30 atti 5 [	Other (sp	еспу)							
<u> </u>	res that signed b be deta	by Pr	Part II. Other significant conditions con	tributing to deal	h but not res	sulting in the u	nderlying c	ause give	n in Part I.		23e. Did t	obacco us	se contribute to	the cause of o	death?
Vital Records,	w require. been sig should b	ed b	Dlabeter Mellite	1(							10	Yes 2	No 3□Pro	bably 4 🗆	Unknown
eco	law re as bee	piet	Ventrialoperton	ial Thu	ut						24a. Was		24b. Were aut	opsy findings	available
Ä		Completed	5 tre & foculus VIV	idans in	Lectio	7					autor perfo	rmed?	death?	ompletion of a 2 □ No	ause or
/ita	Physicien: The this certificate ral director, pag	Be (	25. Was case referred to medical examiner?	2.1.4		242		- 1		of Death	Check onl	ne			
of	this al dia	2	1 ☐ Yes 2 ☐ No	ospital: 1 Hmp		ER/Outpatien		-	4 🗆 1401				□Other (Spec	fy)	
no	De la	tion	1 Matural 5 ☐ Pending	28a. Date of (Month,	Day Year)	28b. Time of Injury	. M	8c. Injury Work	at ? ′es 2.⊟N		ld. Describe l	now injury	occurred		
Division	teat feat for: the	fica	3 Suicide 6 Could not be	28e. Place of	Injury - At h	ome, farm, str			63 2 1		f. Location (	Street and	Number or Rui	al Route Num	nber.
ă	i Dife	Certification;	4 Homicide	building	, etc. (Specil	(y)	117	,			City or Tov	vn, State)			
	To the Hospitel or At within 24 hours after or To the Funerel Direct completely filled in by		29a. Certifier 1 Certifying Phys	ician: To the basi	est of my kno	owledge, death	occurred	at the time	e, date and	d place, an	d due to the	cause(s) a	and manner as	stated.	-)
	To the H within 24 To the F complete	Medical	one)	and manner	stated.	ation and/or an				n occurred					·/
	70 Vil.	<	29b. Signature and title of certifier				290	. License	number			29d. Date	signed (Month	Day, Year)	
2	(2)		30. Name and, address of person who co	moleted a	of docate /!	- 02c) (T	Deint'	1000	431	292		//	10/00		
	(3)		MUMAN BOYCE	IPG H	ucian (Iter	3001	Ida	5017	red 1	DR. (	hon	du	CW.	DONKE	_
	Sta	te	31. Date filed (Month, Day, Year)	£2. Reg	istrar's Signa	ature	- 1 YE	7	.46	10.	repe	- (5)	1	- (0)	
	Registr	ar	APR 1 4 2005	5900	J. J.	ADSA.									

			State of Maryland / Department of Health and Maryland / Department of Health and Maryland / Certificate of Death		ene g. <b>2</b> 005   4359
			Decedent's Name (First, Middle, Last)	2. Date of Death Month	Day Year 3. Time of Death
	Physicia /Medic		MAXINE LE ANNA VANCE	APRIL 2	20, 2005 4:01 P <sup>M</sup>
	Examin		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death	1	4c. County of Death
			GENESIS LA PLATA CENTER LA PLATA		CHARLES
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day,	
	Director	-	216-22-2666	MAR.9,1	929 PENNSYLVANIA
	land ow		10a. State 10b. County 10c. City, Town or Location	· · · · · · · · · · · · · · · · · · ·	10d. Inside City Limits
	Mary Inc.	ţ	MARYLAND CHARLES LA PLATA		1 ⊈Yes 2 ☐ No
	r 288	Director	10e. Street and Number 10f. Zip Code	10	g. Citizen of What Country?
	h wit		#1 MAGNOLIA DRIVE 20646		U.S.A.
	deat	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Sp. 14. Was Decedent of Hispanic Origin? (Sp. 15. Was Decedent of Hispanic Origin? (Sp. 16. Was D	pecify Yes or No- o Rican, etc.)	14. Race - American Indian, Black, White, etc.
9	or Ite		1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ② No If Yes, Give 1 ☐ Yes 2 ☑ No Specify:	,	Specify:
21215-0036	72 hours after death with the Maryland "netural; or Iteme 23a or 28a-f show citeal Examiner rust be notified at	d by	31 Wildowed 4 Divorced Year or Dates:		WHITE
7	"net	Completed	15. Decedent's Education (Specify only highest grade completed)  (Give kind of work done during most of work life, DO NOT use retired)	king	16b. Kind of Business/Industry
7	within lene. then "	mc	Elementary/Secondary (0-12) College (1-4or 5+)  1.2 COMPTROLLER		J.S. GOVERNMENT
	Hyg ther nt,	Be C		ne (First, Middle, M	
Maryland	2 should be and Mental I is marked o	To B	JOSEPH RALPH CARTZENDAFNER LAMORA	PAULINE	FINK
ary	2 shou and N is man		19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rus	ral Route Number,	City or Town, State, Zip Code)
	rt 23 light		BARBARA HINTON-DAUGHTER 7492 SHIRLEY BLVD.		COBACCO, MD 20677
altimore,	0 0		20a. Method of Disposition 1	Date 2	20c. Location - City or Town, State
Ĕ			`4 Donation 5 Other (Specify) TRINITY MEMORIAL GDNS. 4-	-23-05 _	WALDORF, MARYLAND
Balt	permit. Pag Department Importent: any injury ance.		21. Signature of Funeral Service Licensee MOO479 22. Name and Address of Facility AYMOND FUNERAL	CEDVIC	
_	<b>₹</b> □ 12 € 04			AND 20	
D.			shock, or heart failure. List only one care on each fine.	or respiratory arre	Interval Between Onset and D
100	Pnysician		Immediate Cause (Final disease or condition resulting in death)  a. CHONICIEM TO THE STATE OF TH	wre	Lyeur
	/Medical Examiner		Due to (or as a consequence of):	)	Ψ. (2)
Н		r.	Sequentially list conditions, if any leading to immediate  Due to (or as a consequence of):		2 WK
./	ted nsit	nin e	cause. Enter Underlying Cause (Disease or injury		* Dones
, v	execu n and ial-tra	Examiner	that initiated events resulting in death) Last   Due to (or as a consequence of):		3
8760,	The law requires that the death certificate be executed the sabeen signed by the attending physicien and tate 2 should be delached for use as the burial-transit	dicail	d		
9	tificat ig phy as th	ledi			
ŏ	death certifica attending ph d for use as th	N/UE	IF FEMALE: 23b. Was decedent pregnant  23c. If yes, outcome of pregnancy  1 □ Live birth  2 □ Fetal death  3 □ Ectopic pregnancy		23d. Date of delivery
B.	deat of for	Physician/Me	in the past 12 months?  1 ☐ Yes 2 ☐ No   4 ☐ Pregnant at time of death 5 ☐ Other (specify)		Month Day Year
P.0	that the de led by the a detached f	Phy	9 U Unknown	Ogo Did toh	pacco use contribute to the cause of death?
	res tha igned be del	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		s 2 No 3 Probably Wunknown
orc	w require been si should b	eted			
Records,	e law has b	Completed		24a. Was ar autops perform	y prior to completion of cause of
E	icien: The lav certificate has rector, page 2			1 ☐ Yes 2	No 1 Yes 2 No
Vital	Physicien: this certific ral director,	Be	examiner?	ath (Check only on	e) ance 6 □Other (Specify)
of	Phys r this sral di	To To			ow injury occurred
lon	Attending F r death. sctor: After by the funeri	tlor	1 Augural 5 Pending (Month, Day Year) Injury Work? 2 Accident investigation M 1 Yes 2 No		
Division	Attendi	ifica	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (St. City or Town	reet and Number or Rural Route Number,
Ö	s afte	Certification:	4 - Rominade Sullding, etc. (Specify)	Only or round	, dialo,
	To the Hospitel or Attending Physicien: The within 24 hours after death.  To the Funerel Director: After this certificate his completely filled in by the funeral director, page			e, and due to the ca	ause(s) and manner as stated.
	To the H within 24 To the F complete	ledical			
	To To	Σ	29b. Signature and the of certifier	70	9d. Date signed Month, Day, Year)
			A TON HOW IN DOLL	0	1/20/01
	10		30 Name an address of pers in the completed cause of death (Item 23a) (Type, Print)	Dorce	MO 70602
	10		31. Date filed through Day, Year) 32. Registrar's Signature	- • • •	- 0 - 0 - 5
	Sta Regist		31. Date-filed Mygly Day, Xear 2005		

			1 - For State Registrar	State of M	aryland /		artmen rtificate					Reg. No.	2005	14360		
	Physici	an	1. Decedent's Name (First, Middle, Last)  DAVID I	HERRERT W	ITT.I.ARD						2. Date of Dea Month April	11 <sup>Day</sup>	2005°	3. Time of Death 6:06 A M		
	/Medic Examin		As Franchisco March 1997 to a second control of the Control of the								трттт	k				
	Funeral Director			7. Ag	je (In yrs. last i 61	birthday) Yrs.	If Under Months	1 Year Days	If Under 2 Hours	4 Hrs.	B. Date of Birt (Month, Day NOV • 1	Birth Pear 1943 9. Birthplace (State or Foreign County) Mary Land				
	e Maryland 3a-f show	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location  Maryland Frederick Thurmont									10d. Inside City Limit					
	h with th	al Director	10e. Street and Number 13433 Catoctin Ho	llow Road	ł		10f. Zip	Code 2178	8				on of What Cour	ntry?		
920	n 72 hours after death with the Maryland "natural", or itams 23a or 28a-f show salest Examinar must be notified at	by Funeral	11. Marital Status  1 Never Married 2 Married  3X Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 Pyes 2 If If Yes, Give 7 Year or Dates.	No		Was Deced If Yes, spec		spanic Orig n, Mexican, Specify:	in? (Spec Puerto R	ify Yes or No- ican, etc.)	}	Race - Americ Black, White, Specify: Wh			
Maryland 21215-0036	C _ 9	Completed	15. Decedent's Edui (Specify only highest grade Elementary/Secondary (0-12)		5+)	(Give	DO NOT us	rk done d se retired,	urina most			Gens	tof Business/In tar & of Fre	ŕ		
yland	d 2 should be filed within and Mental Hygiene. 77 ia marked other than traumatic event. It a M	To Be (	17. Father's Name (First, Middle, Last) Herbert Eugene Wi	llard					18. Mother Mary		(First, Middle, ers	Maiden S	umame)			
	and 2 she lealth and m 27 ia m		19a. Informant's Name/Relationship (Ty, Betty Willard (Si:		1.	3425	Cato	ctin		ow Ro	oad, Th	-	nt, MD			
Baltimore,	of H		20a. Method of Disposition  1   ☐ Burial 2 ☐ Cremation 3 ☐ R  1 ☐ Donation 5 ☐ Other (Specify)	emoval from State		tery, crer	sition (Nan natory or o pect	ther place		Da /14/0			town, M			
Balt	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service License	tout	>	61	5 EAS	T MA	IN ST	., TI	HURMON	Γ, MD	HOMES, 1	P.A.		
	Physician /Medical Examiner	Examiner	23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as	s a consequence	ee of):	CYIN	e of dying	) such as o	Las	Cles	Can	ncer	Approximate Interval Between Onset and Death		
P.O. Box 68760,	that the death certificate be executed ted by the attending physician and detached for use as the burial-transit	Physician/Medical Ex	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal dea it time of death	ith 3[	Ectopic pr	ecity)			00. 5:44	23d. Date of delivery Month Day Year				
ords,	w requires that been signed should be de	ted by	Part II. Other significant conditions con		out not resulting	g in the u	nderlying c	ause give	en in Part I.		1 🗆 Y			ne cause of death?  Pably 4 Unknown		
al Record	The far ate has page 2	Completed											24b. Were auto prior to con death? 1 \(\sum \text{Yes}\)	psy findings available impletion of cause of		
ion of Vital	Attanding Physician: sr death. actor: After this certific by the funeral director,	ation: To Be	25. Was case referred to medical examiner?  1 Yes 2 No  27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	lospital: 1 Inpati 28a. Date of Inju (Month, Da	ury 28b	Outpatier  Time of Injury		8c. Injury Work	r. 4 □ Nur	sing Hom	(Check only one 5 Resided Resided Rescribe h	dence 6	□Other (Specifi	v)		
Division	tal or Atta s after der al Diracto ed in by th	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)								8f. Location (S City or Tox		Number or Rura	I Route Number,		
	To tha Hospital or within 24 hours after To tha Funaral Dirac completely filled in b.	edicai	29a. Certifier (Check only one)  1 Certifying Physical Exemination (Check only one)	sicien: To the best ner: On the basis of and manner si	of examination	lge, deatl and/or in	n occurred vestigation,	at the tim , in my op	e, date and inion, deat	l place, ar h occurred	d due to the d	cause(s) a date and p	nd manner as si lace, and due to	ated. the cause(s)		
)	with com	Σ	29b. Signature and title of cedifier	3				D43	-				signed (Month,			
	9			idi	80		Print) TOLL	He	we	Ave	R	rder	-13-05	47		
	Sta Registi		31. Date filed (Month, Day, Year) APR 13 20	005 32. By gist	rar's Signature	a de		P								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1 - State Registrar

Certificate of Death

1. Decedent's Name (First, Middle, Last)

2. Date of Death Month Day Year

		Registrar			Cen	ificate of D	Jealii		Reg. N	6000	1430
		1. Decedent's Name (First, Middle, La	ist)					2. Date of D			3. Time of Death
Physic		Davis Wils	200					Month April		ay Year	4-10 amm
/Med Exami		4a. Facility Name (If not institution, given				4b. City, Town, or	Location			c. County of Death	1.00(1)
Exam		University of mo	solved Ma	Alm Con	Ler	Brillian	0	Maryland	1	Baltimova	o City
				(In yrs. last bi		If Under 1 Year	If Under	24 Hrs. 8. Date of E	3irth	9. Birtho	lace (State of Foreign
Funeral Director			1¥TM 2□E	39		Months Days	Hours	Min. (Month, I	<i>Эау, Үөа</i>		lace (State of Foreign
		Usual Residence of Decedent						June	2/ 1	965   Mary	Tand
land ow		10a. State 10b. County		10c. City, Tow	m or Loca	ation				1	0d. Inside City Limits
f sh	ō	Maryland Carolin	_	17 1 -							1 ☐ Yes 2X No
The P	Directo	10e. Street and Number	e	Hende	rson	10f. Zip Code			100.0	Citizen of What Cour	day?
with with			- n.d. T - 4 17(								itt y r
ath	Funeral	16840 Henderson R			1.0.11	21640				JSA	
er de	5	11. Marital Status	12. Was Decedent E Armed Forces?		13. W	as Decedent of His Yes, specify Cubar	spanic Or n, Mexica	rigin? (Specify Yes or f n, Puerto Rican, etc.)	NO-	14. Race - Americ Black, White,	
s aft	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🕅 Divorced	1 ☐ Yes 2 🛣 N If Yes, Give	10	1 (	Yes 2XNo	Specify:	:		Specify:	• .
hours after death with the Maryland hours after death with the Maryland turel; or Items 23a or 28e-f show at Examiling indicates			Year or Dates:	1						L	ite
72 72 die	Completed	15. Decedent's E (Specify only highest gr	ducation ade completed)	16a	(Give ki	ind of work done di	uring mos	st of working	16b.	Kind of Business/Inc	dustry
ithin dithin	du	Elementary/Secondary (0-12)	College (1-4or 5-			O NOT use retired)				<i>c</i>	
filed within 72 Hygiene. other than "nai	S	12		1	Labo						ng industry
be filed within 72 hours after death with the Marylan Ital Hygiene. Id other than "naturel", or Items 23a or 28e-f show event, the Mickel Examinatinating at	Be	17. Father's Name (First, Middle, Las					18. Moth	er's Name (First, Midd	le, Maide	en Surname)	
	၉	Norman Davis Wil	son				Doro	othy Franci	is La	ane	
s 1 and 2 should be filed within Health and Mental Hygiene. Item 27 is marked other than other traumatic event, Ira M.		19a. Informant's Name/Relationship	(Type, Print)	198	b. Mailing	Address (Street a	nd Numb	er or Rural Route Num	ber, City	or Town, State, Zip	Code)
1 and 2 Health em 27	1 3	Stacie Johnson/	former wife	e 1	8240	LePore H	Road	Lot10 Mary	del:	, MD 21649	9
s 1 and st Health item 27 other tr		20a. Method of Disposition		20b. Place o	of Disposi	ition (Name of atory or other place	a)	Date	20c.	Location - City or To	wn, State
permit. Pages Department of I Important: if its any injury or o		1   Burial 2 □ Cremation 3   '4 □ Donation 5 □ Other (Speci	∴Removal from State	1		o Cemeter	1	4/19/2005	Gre	ensboro,	Maryland
artm orta		21. Signature of Funeral Service Lice		, 020011							
permit. Pages Department of Important: If it any injury or once.		Adres 1	FR	1.	F1	eegle and	He]	<sup>ity</sup> lfenbein Fu ensboro, MI	nera	1 Home, I	PA.
		23a. Part1. Enter the disease, or con	nplications that caused	the death. Do						039	Approximate
		shock, or heart failure. List only Immediate Cause (Final	one cause on each lin	ιθ.	Α.			8	1122		Interval Between Onset and Death
Physician	_	disease or condition resulting in death)	a. Kuptu	red 1	Ane	uysm	0	Suphera	26	ruft	
/Medical Examine		Todaking in addition	Due to for as a	a consequence	of):	8					
		Sequentially list conditions,	b								
D is	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	a consequence	Ot):						
and tran	Eam	that initiated events resulting in death) Last									
be ex ician a			C		-45						
ate b nysic he b	400	1930 tillig ill death Last	C. Due to (or as a	a consequence	of):	· · · · · · · · · · · · · · · · · · ·					
	20	resulting in usality Last	C. Due to (or as a	a consequence	of):						
ng pl	Aedica		Due to (or as a	a consequence	of):						
h certificate be executed anding physician and use as the burial-transit	in/Medicai	IF FEMALE: 23b. Was decedent pregnant	d	of pregnancy		Setorio prograna				23d. Date of delive	ory
death certific e attending pl		IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	d	of pregnancy 2   Fetal deat!	h 3□E	Ectopic pregnancy Other (specify)				23d. Date of delive	ory Day Year
the death certification by the attending place as the control of t		IF FEMALE: 23b. Was decedent pregnant	d	of pregnancy 2   Fetal deat!	h 3□E	Ectopic pregnancy Other (specify)					,
, F.O. DOA OF	Physicia	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	23c. If yes, outcome of 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	of pregnancy 2   Fetal death time of death	h 3 🗆 E	Other (specify)	n in Part	I. 23e. Dic	d tobacco		Day Year
uires that the death certifications by the attending plid be detached for use as I	by Physicia	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  Part II. Other significant conditions	23c. If yes, outcome of 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	of pregnancy 2   Fetal death time of death	h 3 🗆 E	Other (specify)	n in Part			Month  use contribute to the	Day Year
requires that the death	by Physicia	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown  Part II. Other significant conditions	d.  23c. If yes, outcome of the contributing to death but the contributing to death but the contributing to death but the contributing to death but the contributing to death but the contributing to death but the contributions are contributing to death but the contributions are contributing to death but the contributions are contributing to death but the contributions are contributions are contributions.	of pregnancy 2   Fetal death time of death	h 3 🗆 E	Other (specify)	n in Part	1	] Yes	Month  o use contribute to the 2 No 3 Prob	Day Year  The cause of death?  The cause of death?
law requires that the death as been signed by the atte	by Physicia	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  Part II. Other significant conditions	d.  23c. If yes, outcome of the contributing to death but the contributing to death but the contributing to death but the contributing to death but the contributing to death but the contributing to death but the contributions are contributing to death but the contributions are contributing to death but the contributions are contributions are contributions.	of pregnancy 2   Fetal death time of death	h 3 🗆 E	Other (specify)	n in Part	1 [ 24a. Wt	Yes as an topsy	Month  o use contribute to the contribute to the contribute to the contribute to the contribute to the contribute to contribute to contribute to contribute to contribute to contribute to contribute to contribute to contribute to contribute to contribute to the contribute to con	Day Year
The law requires that the death are has been signed by the atterpage 2 should be detached for	Physicia	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown  Part II. Other significant conditions	d.  23c. If yes, outcome of the contributing to death but the contributing to death but the contributing to death but the contributing to death but the contributing to death but the contributing to death but the contributions are contributing to death but the contributions are contributing to death but the contributions are contributions are contributions.	of pregnancy 2   Fetal death time of death	h 3 🗆 E	Other (specify)	n in Part	1 [ 24a. Wt	Yes as an topsy	Month  o use contribute to the contribute to the contribute to contribute to content to	Day Year  The cause of death?  The cause of death?  The cause of death?  The cause of death?
The law requires that the death are has been signed by the atterpage 2 should be detached for	by Physicia	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown  Part II. Other significant conditions  Cana Arxen  25. Was case referred to medical	23c. If yes, outcome of the contributing to death but the contributing to death but the contributing to death but the contributing to death but the contributing to death but the contributing to death but the contributing to death but the contributing to death but the contributing to death but the contributing to death but the contribution of th	of pregnancy 2   Fetal death time of death	h 3 🗆 E	Other (specify)	26. Plac	24a. Wu	Yes as an topsy formed?	Month  o use contribute to the contribute to the contribute to contribute to content to	Day Year  The cause of death?  The cause of death?  The cause of death?  The cause of death?
The law requires that the death are has been signed by the atterpage 2 should be detached for	e Completed by Physicia	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown  Part II. Other significant conditions  Conomy Active	d.  23c. If yes, outcome of the contributing to death but the contributing to death but the contributing to death but the contributing to death but the contributing to death but the contributing to death but the contributions are contributing to death but the contributions are contributing to death but the contributions are contributions are contributions.	of pregnancy 2	h 3 E	Other (specify)	26. Plac	24a. Wi au pe	Yes as an topsy formed? 2 \( \) \( \	Month  o use contribute to the	Day Year  The cause of death?  The cause of death?  The cause of death?  The cause of death?  The cause of death?
The law requires that the death are has been signed by the atterpage 2 should be detached for	To Be Completed by Physicia	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown  Part II. Other significant conditions  25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death	23c. If yes, outcome of the little birth and the li	of pregnancy 2 Fetal death time of death ut not resulting	h 3 E	Other (specify)  derlying cause give	26. Plac	24a. Whau au Yes	Yes as an topsy formed? 20 N	Month  o use contribute to the contribute to contribut	Day Year  The cause of death?  The cause of death?  The cause of death?  The cause of death?  The cause of death?
in Of Vital mecology, F.C. De ng Physicien: The law requires that the death ther this certificate has been signed by the atternant director, page 2 should be detached for	To Be Completed by Physicia	IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1	d.  23c. If yes, outcome of the line of th	of pregnancy 2 Fetal death time of death ut not resulting	h 3 E	Other (specify)  derlying cause give  3 □ DOA  28c. Injury Work	26. Plac	24a. With au per yes e of Death (Check only ursing Home 5 \square Re 28d. Describ	Yes as an topsy formed? 20 N	Month  o use contribute to the contribute to contribut	Day Year  The cause of death?  The cause of death?  The cause of death?  The cause of death?  The cause of death?
in Of Vital mecology, F.C. De ng Physicien: The law requires that the death ther this certificate has been signed by the atternant director, page 2 should be detached for	To Be Completed by Physicia	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown  Part II. Other significant conditions  Control  25. Was case referred to medical examiner? 1   Yes 2   Yes  27. Manner of Death 15. Natural 5   Pending investigatic 3   Suicide 6   Could not	23c. If yes, outcome of the line of the li	of pregnancy 2   Fetal death  time of death  ut not resulting  nt 2   EP/O y y Year) 28b.	n 3 E	Other (specify)  derlying cause give  3 □ DOA Othe  28c. Injury Work  M 1 □ Y	26. Place  7: 4 □ Note  at  ?	24a. With au per yes e of Death (Check only ursing Home 5 Re 28d. Describ	Yes as an atopsy rformed? 2 \( \) \(	Month  o use contribute to the contribute to the contribute to the contribute to the contribute to the contribute to the contribute to the contribute to contribute to contribute to contribute to contribute to contribute to the contribute to contr	Day Year  The cause of death?  The cause of death?  The cause of death?  The cause of death?  The cause of death?  The cause of death?
in Of Vital mecology, F.C. De ng Physicien: The law requires that the death ther this certificate has been signed by the atternant director, page 2 should be detached for	To Be Completed by Physicia	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	23c. If yes, outcome of the line of the li	of pregnancy 2 Fetal death time of death  ut not resulting  nt 2 EP/O y y Year) 28b.	n 3 E	Other (specify)  derlying cause give  3 □ DOA Othe  28c. Injury Work  M 1 □ Y	26. Place  7: 4 □ Note  at  ?	24a. With au per yes e of Death (Check only ursing Home 5 Re 28d. Describ	as an topsy formed?  2 \( \) N  y one)  sidence e how inj	Month  o use contribute to the contribute to the contribute to the contribute to the contribute to the contribute to the contribute to the contribute to contribute to contribute to contribute to contribute to contribute to the contribute to contr	Day Year  The cause of death?  The cause of death?  The cause of death?  The cause of death?  The cause of death?  The cause of death?
in Of Vital mecology, F.C. De ng Physicien: The law requires that the death ther this certificate has been signed by the atternant director, page 2 should be detached for	Certification: To Be Completed by Physicia	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	23c. If yes, outcome of the line of the li	of pregnancy 2 Fetal death time of death ut not resulting  nt 2 ER/O y Y Year) 28b. ury - At home, f	in the uncountry utpatient Time of Injury arm, street	Other (specify)  derlying cause give  3 DOA  28c. Injury Work M 1 Y et, factory, office	26. Place  T: 4 \( \text{N}\) at ? 'es 2 \( \text{L}\)	24a. With au person of Death (Check only ursing Home 5 Re 28d. Describ	as an topsy rformed?  20 N v one) sidence e how inj	Month  Duse contribute to the	Day Year  The cause of death?  The cause of death?  The cause of death?  The cause of death?  The cause of death?  The cause of death?  The cause of death?  The cause of death?  The cause of death?  The cause of death?  The cause of death?  The cause of death?  The cause of death?  The cause of death?  The cause of death?
in Of Vital mecology, F.C. De ng Physicien: The law requires that the death ther this certificate has been signed by the atternant director, page 2 should be detached for	Certification: To Be Completed by Physicia	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	23c. If yes, outcome of the line of the li	of pregnancy 2   Fetal dealt time of death  at not resulting  nt 2   ER/O y Year) 28b.  ary - At home, f c. (Specify)  of my knowledg examination ai	in the uncountry utpatient Time of Injury arm, street	Other (specify)  derlying cause give  3 DOA  28c. Injury Work M 1 Y et, factory, office	26. Place  T: 4 \( \text{N}\) at ? 'es 2 \( \text{L}\)	24a. With au person of Death (Check only ursing Home 5 Re 28d. Describ	as an topsy rformed?  20 N v one) sidence e how inj	Month  Duse contribute to the	Day Year  The cause of death?  The cause of death?  The cause of death?  The cause of death?  The cause of death?  The cause of death?  The cause of death?  The cause of death?  The cause of death?  The cause of death?  The cause of death?  The cause of death?  The cause of death?  The cause of death?  The cause of death?
in Of Vital mecology, F.C. De ng Physicien: The law requires that the death ther this certificate has been signed by the atternant director, page 2 should be detached for	To Be Completed by Physicia	IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1	d.  23c. If yes, outcome of the line of th	of pregnancy 2 Fetal dealt time of death  at not resulting  nt 2 EP/O y y Year  28b.  ary At home, f. c. (Specify)  of my knowledg examination alted.	utpatient Time of Injury arm, stree	other (specify)  derlying cause give  3 DOA Othe  28c. Injury Work  1 Y  et, factory, office  occurred at the timestigation, in my op	26. Place T: 4 Ni at ? Yes 2 C	24a. With au person of Death (Check only ursing Home 5 Re 28d. Describ	as an topsy of the form of the	Month  Duse contribute to the	Day Year  ie cause of death? ably Unknown  psy findings available inpletion of cause of  No  I Route Number,  ated. the cause(s)
Physicien: The law requires that the death risk certificate has been signed by the atternal director, page 2 should be detached for	Certification: To Be Completed by Physicia	IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1	d.  23c. If yes, outcome of the line of th	of pregnancy 2 Fetal dealt time of death  at not resulting  nt 2 EP/O y y Year  28b.  ary At home, f. c. (Specify)  of my knowledg examination alted.	utpatient Time of Injury arm, stree	other (specify)  derlying cause give  3 DOA Othe  28c. Injury Work  1 Y  et, factory, office  occurred at the timestigation, in my op	26. Place T: 4 Note at at ? Yes 2 Communication, decommendation, 24a. With au person of Death (Check only ursing Home 5 Re 28d. Describ	as an topsy of the form of the	Month  Duse contribute to the contribute to the contribute to the contribute to the contribute to the contribute to the contribute to the contribute to the contribute to the contribute to the contribute to the contribute to the contribute to the contribute to contribu	Day Year  Day Year  The cause of death?  The cause	
in Of Vital mecology, F.C. De ng Physicien: The law requires that the death ther this certificate has been signed by the atternant director, page 2 should be detached for	Certification: To Be Completed by Physicia	IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1	d.  23c. If yes, outcome of the line of th	of pregnancy 2   Fetal dealt time of death  at not resulting  nt 2   EP/O  y Year) 28b.  ary - At home, f c. (Specify)  of my knowledg examination atted.	utpatient Time of Injury arm, streige, death	other (specify)  derlying cause give  3 DOA Othe  28c. Injury Work M 1 York et, factory, office  cocurred at the timestigation, in my op	26. Place T: 4 Note at at ? Yes 2 Communication, decommendation, 24a. With au person of Death (Check only ursing Home 5 Re 28d. Describ	as an topsy of the form of the	Month  o use contribute to the	Day Year  Day Year  The cause of death?  The cause	

State

Registrar

31. Date filed (Month, Day, Year)

APR 1 8 2005

32. Registrar's Signature

		•	FOI	partment of Health and Mertificate of Death	ental Hygie	0000	14362
0	Physicia	an	1. Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year	3. Time of Death
1	/Medic		Eric Olvin Williams, Sr.		April 9	2005	7:00A M
ř	Examin	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	-
	Funeral		Holy Cross Hospital  5. Social Security Number 6. Sex 7. Age (In yrs. last birthd	Silver Spring  By If Under 1 Year   If Under 24 Hrs.	8. Date of Birth	Montgomery 9. Birth	
	Director		577-70-3355 <sup>1⊠M 2□F</sup> 51 Yrs	Months Days Hours Min.	(Month, Day, Y) Ay 30, 1		place (State or Foreign ntry)
	pu *		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town of				
	Aaryla F shor	ō		Washington			10d. Inside City Limits 1 1 1 Yes 2 1 No
	28a-	Director	10e. Street and Number	10f. Zip Code	100	. Citizen of What Cou	ntry?
	3a or	<u></u>	3109 Marquis Dr.	20744		nited State	-
9	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel", or Items 23a or 28a-f show samp injury or other traumatic event, Ite Medical Exactinal most be rivilled at ODGe.	by Funeral	1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☑ No	3. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto If 1 ☐ Yes 2 ☑ No Specify:	cify Yes or No- Rican, etc.)	14. Race - Ameri Black, White, Specify: B1:	etc.
Ö	hours turel',	q p	3 Wildowed 4 Divorced Year or Dates:	•			
<u> </u>	in 72 n "nat	Completed	(Specify only highest grade completed) (G	cedent's Usual Occupation ive kind of work done during most of workir e. DO NOT use retired)	ng 16	ib. Kind of Business/Ir	ndustry
212	yiene.	шо	Elementary/Secondary (0-12) College (1-4or 5+)	trepreneur		Privat	:e
D D	al Hyg I othe	Be C	17. Father's Name (First, Middle, Last)	18. Mother's Name	(First, Middle, Ma	iden Sumame)	
<u>yla</u> i	Menta Menta arked	To	Charlie Mack Williams	Lee Flora	a Wiggs		
Maryland 21215-0036	12 sh h and 7 Is m reum	( 2)	1.2.	ailing Address (Street and Number or Rura			
e,	t and Health em 2		20a Method of Disposition 20b, Place of Di	9 Marquis Dr., Ft. V		on, Ma. 20	)744 own. State
Baltimore,	ages ant of it: If it y or c		1 🖾 Burial 2 □ Cremation 3 □ Removal from State cemetery,	prematory or other place)			
altir	mit. F partme sortan r injur	ı	21. Signature of Funeral Service Licensee		16,2005 ge Funer <i>a</i>	Brentwood, I Homes	MD.
m	Ped Line		Fath a save MO1005	For	ge Funera 88 Marlbo restville	oro Pike , Md. 207	747
			23a. Part1. Exter the disease or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.				Approximate Interval Between
	Pnysician	2 - U	Immediate Cause (Final disease or condition a. Amyotrophic L	ateral Sclerosis			Onset and Death 13 months
	/Medical Examiner		resulting in death)  Due to (or as a consequence of):				ace Talance History (Chilese of
		ē	Sequentially list conditions, if any, leading to immediate b.  Due to (or as a consequence of):				
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.				
oʻ	an and rial-tra	Exa	resulting in death) Last   Due to (or as a consequence of):				
8760,	cate be executed physician and the burial-transit	dlcal	d				
9	ertifica Jing pl	/Med	IF FEMALE:				
Вох	that the death certific ed by the attending p detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy  1 Live birth 2 Fetal death  4 Pregnant at time of death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of deliv Month	ery Day Year
P. O.	that the de ned by the a detached f	nyslo	1 U Yes 2 No 9 Unknown 9 Unknown	Other (specify)			
	res that igned b be deta	by Pt	Part II. Dther significant conditions contributing to death but not resulting in the	e underlying cause given in Part I.	23e. Did toba	cco use contribute to t	he cause of death?
Records,	- o -	ed t	Aspiration Pneumonia		1 ☐ Yes	2 √No 3 ☐ Prol	bably 4 Unknown
ecc	e law requ has been je 2 shouk	plet			24a. Was an autopsy	24b. Were auto	opsy findings available empletion of cause of
Œ.	(0)	Completed			performe	d? death?	2 No
Vital	iclen: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	26. Place of Death	(Check only one)		
of	ohys this al dii	To:	1 ☐ Yes 2X No Hospital: 1 ☒ Inpatient 2 ☐ ER/Outp:  27. Manner of Death 28a. Date of Injury 28b. Tim		ne 5 Resident	ce 6 ☐Other (Speci	fy)
OU	Attending I r death. sctor; After by the funer	tion	27. Manner of Death  1 X Natural 5 □ Pending 2 □ Accident investigation  28a. Date of Injury (Month, Day Year) Inju 28b. Tim Inju		.00. 5000.150	mary coodinad	
Division of	l or Attendil after death. Director: A	Certification;	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm building, etc. (Specify)	, street, factory, office	28f. Location (Stre City or Town,	et and Number or Run State)	al Route Number,
Ö	itel or A irs after rel Direc lled in by	Cer	Building, d.c. (epochy)				
	To the Hospitel or At within 24 hours after of To the Funerel Direct completely filled in by	edical	29a. Certifier 1☐ Certifying Physician: To the best of my knowledge, of (Check only one) 2☐ Medical Examiner: On the basis of examination and/cand manner stated.	eath occurred at the time, date and place, a r investigation, in my opinion, death occurre	and due to the cau ed at the time, date	se(s) and manner as s and place, and due t	stated. o the cause(s)
	To the within 2. To the complet	Med	29b. Signature and title of certifier	29c. License number	290	I. Date signed (Month,	Day, Year)
	ر کرد		J. Chen mo	D0045/2/	1	April 9	2005
1	601		30. Name an arress of person who ample of cause of death (Item 23a) (Ty	ne Print) .	01		20910
<b>1</b> -	- 150)		Brian Keagan 1500 to	rest Glen Rd.	21/1	ver Spn	ing, MD.
	Sta Regist	ate rar	31. Date filed (Month, Day, Year)  APR 1 4 2005	and .		1	0'

State of Maryland / Department of Health and Mental Hygiene 1 - Stata Registra Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** 10, JUANITA DELORES WRIGHT APRIL 2005 5:37A /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner FORT WASHINGTON HOSPITAL PRINCE GEORGES FORT WASHINGTON If Under 1 Year If Under 24 Hrs. 8. Date of Birth

Month, Day, Year)

Min. (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) **Funeral** 1 □ M 2XXF Months Yrs. Director 579 46 4040 70 31, 1935 WASHINGTON, DC Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits show item 27 is marked other then "natural", or items 23a or 28a-f show other treumstic event, I'm Modical Eversities must be notified at XX Yes 2 No Director MARYLAND PRINCE GEORGES FORT WASHINGTON 10g. Citizen of What Country? 12021 LIVINGSTON ROAD 20744 Completed by Funeral UNITED STATES 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ŽŽNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes XX No Specify: Specify: BLACK 3 Widowed XX Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 6ТН HOMEMAKER DOMESTIC 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be finent of Health and Mental Fint: If item 27 is marked of 10 HARRY MARSHALL MARIE WILLIAMS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JANET WRIGHT / DAUGHTER 3942 SUITLAND RD. #202 SUITLAND, MD 20746 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State XX Burial 2 Cremation 3 Removal from State ö permit. Page Department of Importent: If any injury or once. <sup>1</sup> 4 □ Donation 5 □ Other (Specify) CEDAR HILL CEMETERY | 04/15/2005 SUITLAND, MD 21. Signature of Funeral Service 22 Name and Address of Eaching MARSHALL'S FUNERAL HOME OF MARYLAND, INC. 4308 SUITLAND ROAD SUITLAND, MD 20746 Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Arivation Mermonia /Medical Due to (or as a consequence of): Examiner levelover all acribe Sequentially list conditions, Due to (or as a consequence of) Examiner cause. Enter Underlying Cause (Disease or injury that initiated events burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) Box 68760, Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death 5 Other (specify) P.O. the 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 2 No 1 Yes Hospitel or Attending Physicien: Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending after death. Director: A 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical To the Hosp within 24 ho To the Func (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature as D0055120 :Mi) Name and address of person who completed cause of death (Item 23a) (Type, Print) Suthen Avenue Sinte 310 Washington DC 1325 ALMER m 31. Date filed (Month, Day, Year) APR 1 4 2005 State Registrar

		-	For State Registrar	State of Ma		artment of H		nd Mental Hy	giene Reg. No.	005	1436	5 L
	Physici /Medic	_	Decedent's Name (First, Middle, L     Rudolph	wood				2. Date of De Month April	ath Day	Year 2005	3. Time of Do	eath M
ø	Examin		4a. Facility Name (If not institution, gi	ING HOME	(In yrs. last birthday)	4b. City, Town, or  LEONARD'  If Under 1 Year			S	Ounty of Death  T. MARY		Foreign
	Funeral Director		578 66 4259 Usual Residence of Decedent	1 <b>X</b> ) M 2□ F	55 Yrs.	Months Days	Hours	Min. (Month, Da NOV • 25	y, Year)	9 WASI	place (State or F ntry) HINGTON	D.C.
	the Marylar 728e-f show putition at	rector	10a. State 10b. County  MARYLAND CHARLES  10e. Street and Number	COUNTY	10c. City, Town or Lo				10g. Citize	en of What Cou	10d. Inside City  X Yes 2  ntry?	
36	be filed within 72 hours after deeth with the Maryland that Hygiene. sd other then "naturel", or items 23s or 28e-f show event, the Medical Examinat must be multised at	by Funeral Director	307 VAN BUREN RO.  11. Marital Status  1 Never Married  Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1  Yes, Give Year or Dates:	0		0602 lispanic Orig an, Mexican, Specify:	nin? (Specify Yes or No Puerto Rican, etc.)		USA  Race - Ameri Black, White,	etc.	
21215-0036	filed within 72 hou Hygiene. Ither then "nature ant, tre Medical E	Completed	15. Decedent's (Specify only highest g	Education rade completed) College (1-4or 5- 2	(Give	dent's Usual Occup kind of work done DO NOT use retired INSELOR	during most d)		F	of Business/Ir	ndustry	
Maryland	should be filt and Mental Hy marked oth umatic event	To Be	17. Father's Name (First, Middle, Las WILLIAM NORMAN W				J	r's Name (First, Middle, JUANITA LYL	ES			
	and 2 sealth ar to 27 is ner treu	1 6	19a. Informant's Name/Relationship GLORIA LUZ /WIFE	(Type, Print)	CALLE	FAUSTI		REZ 584 CO	СНАВА	MBA-BOI	LIVIA	
Baltimore,	permit. Pages 1 Department of H Importent: If iter any injury or ott		20a. Method of Disposition  1 □ Burial 2 ★ Cremation 3  '4 □ Donation 5 □ Other (Spectary Spectary Special S	ify)	METROPOLI	TAN CREMAR Name and Address	ATORY	Date 4-21-2005 MARSHALL'S DAD SUITLAN	ALEX	ERAL HOM	VIRGIN ME OF MD	
R.	Physician /Medical Examiner		23a. Part1. Enter the disease, or co- shock, or heart failure. List onl Immediate Cause (Final disease or condition resulting in death)	a. CAR	the death. Do not ende.  CINOMATOSI  consequence of):  CREATIC CA	S	ng, such as o	cardiac or respiratory a	rrest,		Approximate Interval Betwe Onset and Dea ONTHS  MONTHS	
8760,	sate be executed bhysician and the burial-transit	ilcal Examiner	if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a	a consequence of):	ANGER					MONTHS	
.O. Box 6	death certific e attending p od for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death 3	Ectopic pregnancy Other (specify)	′		23	d. Date of deliving Month	ery Day Yea	ar
rds, P	S US 0	by	Part II. Other significant conditions ADULT IMMUNE DEF			nderlying cause giv	en in Part I.	23e. Did t	_		he cause of dea	
Vital Record	The law ate has b page 2 sl	Completed	HEPATITIS C					24a. Was autor perfo	osy ormed?	24b. Were auto prior to co death? 1 \( \text{Yes}	opsy findings ava empletion of cause	ailable se of
ō	Attending Physician: 1 r death. sctor: After this certifical by the funeral director, p	ation; To Be	25. Was case referred to medical examiner?  1  Yes 2 No  27. Manner of Death  1 Natural 5 Pending investigat	28a. Date of Injur (Month, Day	nt 2 ER/Outpatien y 28b. Time of Injury	f 28c. Injur Wor	er. Nur	of Death (Check only of ring Home 5 Residue)  28d. Describe	dence 6		fy)	
Division	i gite	Certification;	3 ☐ Suicide 6 ☐ Could not determine		iry - At home, farm, st c. (Specity)	reet, factory, office		28f. Location (. City or To		Number or Rur	al Route Numbe	r.
	Hos Fur	edical		Physician: To the best of aminer: On the basis of and manner sta	examination and/or in							
	to	Z	29b. Signature and title of certifier	Plan	WEAL	29c. Licens	D0641	18		signed (Month,		
1	. 6		30. Name an Valiriess of person who	E, M.D.		Print) DICH ROAD	HOLLY	WOOD, MD 2	0636			
	Sta Regist	ate rar	31. Date file (Month, Day, Year) APR 1 4 200	5 B2. Registra	r's Signature	S)						

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

/sicia	an	1. Decedent's Name (First, Middle, Last) Alice Wheaton				2. Date of Death April 4	Day 2005 Yea	3. Time of Death 0300A. M
ledic amin		4a. Facility Name (If not institution, give si	reet and number)	4b. City. Town	or Location of Death	,	4c. County of De	
a1111111	C1	Prince Georges Ho		Chever	1v		Prince (	
eral ctor		5. Social Security Number 579-50-9124 6. Sex 1□	7. Age (in yrs. last b.	irthday) If Under 1 Yea Months Day		8. Date of Birth Oct 10,	1934 N	Birthplace (State or Foreign Country) Orth Carolin
	}	Usual Residence of Decedent  10a. State 10b. County	10c. City, Toy	vn or Location				10d. Inside City Limits
Bod	tor	MD Prince Ge	eorge's N. 1	Brentwood				1 □Yes 2 🙀 No
be notified at	Director	10e. Street and Number	0	10f. Zip Code		100	. Citizen of What	Country?
d la	alD	3909 Wallace Road	1		20722		USA	
9	Funeral		2. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of If Yes, specify Control	Hispanic Origin? (Spaniban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ar Black, W	merican Indian, hite, etc.
Examiner must	by F	1 ☐ Never Married 2 🔀 Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 XNo If Yes, Give Year or Dates:	1□Yes 2☒N	o Specify:		Specify: 1	olack
180		15. Decedent's Educ		Decedent's Usual Occ	upation	16	b. Kind of Busine	ss/Industry
Mad	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	a. Decedent's Usual Oct (Give kind of work dor life. DO NOT use ret	4	ing		
3	Con		0	homema			own ho	me 
9/9	Be	17. Father's Name (First, Middle, Last) Clayton Pheiffer				e (First, Middle, Ma Ransfor		
matic	ို	19a. Informant's Name/Relationship (Typ	a Print) 19	b. Mailing Address (Stre				a Zin Code)
trau		Perry Wheaton/son	·	1909 Wallace		Brentwoo	•	0722
any injury or other traumatic event. The Medical 2008.		20a. Method of Disposition	/ comete	of Disposition (Name of ery, crematory or other p		Date 20	c. Location - City	or Town, State
ury or		1 ☐ Burial 2 ☐ Cremation 3 ☐ Re  '4 ☐ Donation 5 🖾 Other (Specify)	movai irom State	Veterans	1	7/2005 (	Chelten	ham wh
ıy injt		21 Signatur of Funeral S. ryce License			ress of Facility Lomy Board			
g 2	4	23a. Part1. Enter the disease, or complic shock, or heart failure. List only on	Clare	Baltimore	, MD 2120	1		
e burial-transit	cal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence					
the		d.						
tached for use as the	Completed by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 27 No 9 ☐ Unknown	c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal deat 4 ☐ Pregnant at time of death 9 ☐ Unknown	h 3 Ectopic pregnal			23d. Date of o	delivery Day Year
G .	y Ph	Part II. Other significant conditions conf	ributing to death but not resulting	in the underlying cause	given in Part I.	23e. Did toba	cco use contribute	to the cause of death?
9 9	q pa	Hypertensive Ather	osclerotic Card	iovascular	Disease	1 ☐ Yes	2 □ No 3 □	Probably 4 Unknow
ep ec	piet					24a. Was an autopsy	24b. Were	autopsy findings available to completion of cause of
2 should be de	5					performe	d? death	
page 2 should be de	Ö	25. Was case referred to medical				n (Check only one)		
page 2 should be de	Be Cor	examiner?		100 DO 4	ther: 4 Nursing Ho	me 5 Residence 28d Describe how		pecify)
al director, page 2 should be de	To Be	22162 5 140		dipatient 3 DOA	une at		ssaulted	During An
al director, page 2 should be de	To Be	1X∑√x es 2 ☐ No	28a. Date of Injury (Month, Day Year)	Time of 28c. In Injury	ork?	Subject A	OD	
al director, page 2 should be de	To Be	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of Injury (Month, Day Year) 4-4-2005 28e. Place of Injury - At home, Injur	Time of Injury V 50 A M 1	ork? □Yes 2 <b>∑</b> No	Subject A A 3909 Wa 281 Location Sine	Prace Rd	Reporth Bren
al director, page 2 should be de	To Be	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year) 4-4-2005 28b. 22:	Time of Injury V 50 A M 1	ork? □Yes 2 <b>T</b> No e	Subject A A 900 wa 28f Location (Sire City or Town, .	Place Red et and umber or State Prince	Report Haren George M
al director, page 2 should be de	Certification; To Be	27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide  29a. Certifier 1 Certifying Physical Certif	28a. Date of Injury - At home, building, etc. (Specify)	Time of lnjury 28c. In lnjury 50 A M 1 farm, street, factory, office ge, death occurred at the	ork?  ☐ Yes 2 No e  time, date and place,	Subject A A Jour 28f. Location (Sire City or Town, cepital C and due to the cau	et and umber or State 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	as stated.
al director, page 2 should be de	To Be	27. Manner of Death  1 Natural 2 Accident 3 Suicide 4 Homicide  29a. Certifier (Check only  2 No  Pending investigation 6 Could not be determined	28a. Date of Injury 28b. (Month, Day Year) 4-4-2005 28e. Place of Injury - At home, building, etc. (Specify) Scene cian: To the basis of examination a	Time of linjury V 50 A M 1 farm, street, factory, office one, death occurred at the and/or investigation, in m	ork?  ☐ Yes 2 No e  time, date and place,	Subject A  28f. Location Site City or Town.  Spital  and due to the cau ed at the time, date	et and umber or State 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	due to the cause(s)
the funeral director, page 2 should be de	edical Certification; To Be	27. Manner of Death  1 Natural 2 Accident 3 Suicide 4 Homicide  29a. Certifier (Check only one)	28a. Date of Injury 28b. (Month, Day Year) 4-4-2005 28e. Place of Injury - At home, building, etc. (Specify) Scene cian: To the basis of examination a	Time of linjury V 50 A M 1 farm, street, factory, office one, death occurred at the and/or investigation, in m	ork?  ☐ Yes 2  No  e  time, date and place, y opinion, death occurrence number	Subject A  A Could Subject to Sub	et and umber or State The Context of the Context of	onth, Day, Year)

DHMH 17 Rev 1/2001

			For State Registrer	State of Maryland	-	artment of H tificate of L		, -	iene 0 0	5 14366
	Dhysiei	28	1. Decedent's Name (First, Middle, Last)					2. Date of Deat	Day	3. Time of Death
	Physicia /Medic	al	Vincent L. Wool					04	092	005 03524
	Examin	e.	4a. Fecility Name (If not institution, give. THE MEMORIA	1 L HOSP17		4b. City, Town, or EAS	TON	)	4c. County o	LBOT
	Funeral Director		5. Social Security Number 6. Sec. 15	7. Age (In yrs. In 1965) 7. Age (In yrs. In 1965)	ast birthday) Yrs.	If Under 1 Year Months Days	Hours Min.		Year)	Birthplace (State or Foreign Country)     MD
	put 🛦		Usual Residence of Decedent  10a. State 10b. County	10c City	, Town or Lo	cation				10d. Inside City Limits
	Aaryla I sho	ō	MD Dorchest		mbridg					1 Styles 2 No
	28a-	Director	10e. Street and Number	er car	ibridg	10f. Zip Code		1	0g. Citizen of WI	hat Country?
	h with	io is	314 Crusader Road,	Apt. 204		21613				J.S.
	deat	Funeral		12. Was Decedent Ever in U.S Armed Forces?	S. 13. \	Vas Decedent of Hi Yes, specify Cuba	ispanic Origin? (S	Specify Yes or No-	14. Race	- American Indian, , White, etc.
36	72 hours after death with the Maryland natural; or Items 23a or 28a-f show oreal Examiner must be notified at	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:	1	Yes 2⊡ <b>k</b> No	Specify:	10 1 11001 ( 0101)		Black
21215-0036	72 hours af "natural", or		15. Decedent's Edu	cation	16a. Deced	lent's Usual Occupa	ation		16b. Kind of Bus	iness/Industry
215	- FO	Completed	(Specify only highest grad Elementary/Secondary (0-12)	College (1-4or 5+)	life. L	kind of work done of OO NOT use retired	dunng most of wo ()	rking		
	filed wi Hygien Ither th	Con	11		San	itation W			Seaf	
Maryland	2 should be filed within and Mental Hygiene. Is marked other then eumatic event, the Mental County of the Mental C	) Be	17. Father's Name (First, Middle, Last)  Vincent H. Woolfor	a			18. Mother's Na Maude Me	me (First, Middle, M	Maiden Sumame	)
Z	s 1 and 2 should f Health and Men item 27 le marke other treumatic	2	19a. Informant's Name/Relationship (Ty		19b. Mailin			ural Route Number	City or Town, S	itate, Zip Code)
	1 and 2 Health ar tem 27 le		Geraldine Woolford	/wife						MD 21613
Jre,		- 8	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ F	20b. Pl	lace of Dispo	sition (Name of natory or other place		Date	20c. Location · C	City or Town, State
Ĕ	mit. Pages partment of the cortant: If its injury or of a		'4 □Donation 5 □Other (Specify)	. 1 = =	Field	Cemetery	4/16	72005	Church	Creek, MD
Baltimore,	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral School Colors		Le	Name and Address SWis N. W S18 West	atson Fu	neral Hor	TINE VID 21901	
			23a. Part1. Enter the disease, or compleshock, or heart failure. List only or	cations that caused the death	. Do not ente	er the mode of dying	g, such as cardia	c or respiratory arre	est,	Interval Between
	Prysician	8 H	Immediate Cause (Final disease or condition resulting in death)	Hepatom	a					Ordet and Death
	/Medical Examiner		resulting in dealin)	Due to (or as a consequ	ience of):	( REPL				
	#V	e e	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Dye to (or as a consequ	remov of):	CCC CV				
	d d ansit	Examin	cause. Enter Underlying Cause (Disease or injury that initiated events	. hepatite	3					
0	licate be executed physician and s the burial-transit	Exa	resulting in death) Last	Due to or as a consequ	ience of):			-		
8760,	cate b	dicai		d						
9		/Me	IF FEMALE:	3c. If yes, outcome of pregnar	nev				201.5	
Вох	death certific e attending p id for use as	Physician/Me	in the past 12 months?	1 Live birth 2 Fetal 4 Pregnant at time of de	death 3	Ectopic pregnancy Other (specify)		•	23d. Date Mont	of delivery h Day Year
0	0 0 0	hysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown						
S, D	es tha gned be de	ру Р	Part II. Other significant conditions con	ntributing to death but not resu	ılting in the ur	nderlying cause give	en in Part I.		/	oute to the cause of death?
ord	w requir been si should			<u> </u>				1 □ Ye	es 2. ⊒wYo 3	Probably 4 Unknown
Records,	elaw hasb je2st	Completed						24a. Was a autops perform	y pri	ere autopsy findings available for to completion of cause of
alF								1 ☐ Yes 2	10	ath? ☐Yes 2☐No
Vital		o Be	25. Was case referred to medical examiner?	lospital: 1 Inpatient 2 1	ER/Outpatien	Othe	200	ath (Check only on	1	10 - 11
of		n; To	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of	1 3L DOA	4 Linuising F	lome 5 ☐ Reside 28d. Describe ho		
<u>o</u>	fe A P	atio	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	(WOHUI, Day rear)	Injury		Yes 2 □ No			
Division	il or Atten after deat Director; I in by the	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At ho building, etc. (Specify	me, farm, str	eet, factory, office		28f. Location (Sti City or Town	reet and Number n, State)	or Rural Route Number,
	pital		20a Cortifier 1 P Cartifying Phy	pician. To the best of my know	ulodao doath	and the time	o date and place	and due to the ea		
	To the Hospital or At within 24 hours after of To the Funeral Directompletely filled in by	Medical	29a. Certifier 1 Certifying Phy (Check only one) 2 Medicel Exemi	sicien: To the best of my know ner: On the basis of examinat and manner stated.	ion and/or inv	estigation, in my or	ie, date and place pinion, death occi	s, and due to the ca arred at the time, da	uuse(s) and mani ate and place, an	ner as stated.  Indidue to the cause(s)
	To th within To th comp	Me	29b. Signatore and title of certifier	~ ~ ^		29c. License	number	2:	9d. Date signed	(Month, Day, Year)
	02		> Daniel H.	Jun 11/2		139	1887		4/10/	05
	B,		30. Name and address of person who co				- MD 016	0.1		
	10		David H. Smith  31. Date filed (Month, 'Dav, Year)	219 S. Washin		t. Eastor	1 MD 216	ŊŢ		
*	Sta Registr		31. Date filed (Month, Day, Year) 3 20	05 Keen	B A	seek)				

AMEND ITEM/198, Please Type of Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 0 5 14367 For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2005 APRIL 25, **Physician ABELOW** 7:08 PN JOSHUA /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 2909 FALLSTAFF ROAD #31 BALTIMORE N/A If Under 1 Year If Under 24 Hrs. 6. Sex 8. Date of Birth NOV.15, 1907 9. Birthplace (State or Foreign Country) POLAND 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1 M 2 □ F Months Hours Min 97 283-28-0920 Director Usual Residence of Decedent death with the Maryland 10a, State 10b. County 10c. City. Town or Location 10d. Inside City Limits or 28e-f show other treumetic event, the Modical Executive round be notified at 1 Yes 2 □ No Completed by Funeral Director MD N/A BALTIMORE 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? ROAD #31 USA Items 23a 2909 FALLSTAFF 21209 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. Int: If item 27 is marked other then "naturel", or Iter 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify Specify WHITE 3 X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) TAILOR CLOTHING 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be (UNKNOWN) **ABELOW** (UNKNOWN) (UNKNOWN) 19a. Informant's Name/Relationship (Type, Print) 19b. Matting Atteress (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8 RICHARDGREEN COURT - OWINGS MILLS, MD 21117 DAVID ABELOW / SON 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Buriaf 2 Cremation 3 Removal from State ō permit. Page Department of Importent: If any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) BETH TFILOH CEMETERY 04/28/2005 WOODLAWN, MD 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Europral Service Licensee 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part 1. Enter the dilease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart latifure. List only one cause on each line. Approximate Interval Between Immediate Gause (Final disease or condition **Physician** Due to (or as a consequence of) Anteny Disease resulting in death) /Medical **Examiner** Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Physician/Medical Examiner the burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. | 9 Unknown à Part fl. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ Fibrillation 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an Chronic Bench autopsy perform 1 Yes 2 No To the Hospitel or Attending Physicien: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 2 ER/Outpatient 3 DOA After this 28c. fnjury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending s after decreased Director: After 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide in 24 hours.
the Funerel Director of the funeral director of the funeral director of the funeral director of the function of t Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. vithin 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number April 27,2005 H 53088 Cran 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Craig Gold Do 1838 GRENE TRE Baltimore, Maryland 31. Date filed (Month, Day, You APR 2005

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
Amend item. 10e per fh 8842 4-28-05 vt.
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** Boler PM osetta 1:39 22 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Ohns Hopk NSHOSPItal BatiMore Ci. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Min 1 ☐ M 2X F **Director** 218-58-3142 Yrs. 45 June 21,1959 Maryland Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits in then "neturel", or Items 23a or 28e-f show the Medical Examiner must be notified at 1 Yes 20No Director Maryland Baltimore Lansdowne 10e. Street and NTartarian 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death v. Depirtment of Health and Mental Hygiene. Insportant: If item 27 is marked other then "neturel", or items 23a any njury or other traumatic event, the Medical Examines 2008. USA 3215 <del>Tattarian</del> Court 21227 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes ★★No If Yes, Give Year or Dates: XXNever Married 2 ☐ Married Baltimore, Maryland 21215-0036 Black 1 ☐ Yes 2 🔀 No Specify: Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Rite Aid Corp. Assistant manager 12th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) John Henry Boler, Sr. Deloris Mae Lee 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21227 19a. Informant's Name/Relationship (Type, Print) 3215 Tartarian Ct. Lansdowne, Maryland Shaunta Crawford/ Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 4/30705 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Western Star Cemetery Catonsville, Maryland ' 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Chatman-Harris Funeral Home 21. Signature of Funeral Service Ligensee 5240 Reisterstown Rd Baltimore, Md21215 Harry 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Sepsis **Physician** days /Medical Due to (or as a consequence of): Examiner Failure enal Sequentially list conditions, if any, leaving to initial solutions cause. Enter Underlying Cause (Disease or injury Examiner burial-transit The law requires that the death certificate be executed Heratic Failur resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical days the as IF FEMALE esn 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy atter Live birth 2 Fetal death in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) signed by the at d be detached for 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 2 No 1 Yes or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Pes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 28a. Date of Injury (Month, Day Year) completely filled in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident within 24 hours after death To the Funerel Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number Lisa Muna MO Res - 000 22, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LISA MARWELL 600 North Wolfe Street Baltimore 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death U 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** April 26 2005 Michael John Boretzky 5. 27AM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** 352 Townsend Road Essex Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Aug. 26, 1921

8. Birthplace (State or Country)
NewJersey 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min X M 2□ F 153-16-5345 Yrs. Director 83 Usual Residence of Decedent Maryland 10c. City, Town or Location 10b Counts 10a State 10d. Inside City Limits 28e-f show Examiner must be notified at 1 ☐ Yes 2√2 No MD Director Baltimore Essex the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 352 Townsend Road 21221 USA Items 23e Pages 1 and 2 should be filled within 72 hours after death nent of Health and Mental Hygiene. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☆Yes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married ŏ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ▼ No Specify: SpecifWhite 3 XWidowed 4 ☐ Divorced "neturel" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) treumetic event, the Medical 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) MArtins Aircraft Inspector 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Is marked o John Boretzky Anna Bunio 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Stephen Boretzky /son item 27 352 Townsend Road Baltimore MD other 20b. Place of Disposition (Name of Date 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages
Department of I
Importent: If it
eny injury or o
2002. 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State SacredHeartofJesus 4/29/05 Baltimore `4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licenses ConnellyFuneralHomeofEssex onne 300 Mace Ave. Baltimore MD 21221 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or comshock, or heart failure. List only complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest only one cause on each line. Immediate Cause (Final rostate Physician Conce disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed use as the burial transit and Due to (or as a consequence of): Box 68760. attending physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy in the past 12 months? ģ Month 4☐Pregnant at time of death 5 ☐ Other (specify) P.0. 9 Unknown à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ pe Metastases 1 Yes 2 No 3 Probably 4 Unknown funeral director, page 2 should Be Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? 2 No 1 Yes 2 No 1 Yes Hospitel or Attending Physicien: 25. Was case referred to medical 26. Place of Death (Check only one, examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA Certification: To 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After Injury 1 **M**Natural 5 Pending within 24 hours after death. To the Funerel Director: A 1 ☐ Yes 2 ☐ No investigation 2 ☐ Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 29a. Certifier 🙀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 024356 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Weinbey Concer Center at Fronkle Lewer Wmc Waterfield MO 9103 Franklin & Ar Boltimore Md 21237

DHMH 17 Rev 1/2001

Registrar

31. Date filed (Month, Day, Year)

32. Degistrar's Signature

			1 - For State Registrar	State of Ma		artment of Hertificate of D		ental Hygiene	DOE	11,370
	Physici /Medic		1. Decedent's Name (First, Middle Joan M B)	Last)				2. Date of Death Month Da	y Year	3. Time of Death  1737 M
	Examir	er	4a. Facility Name (If not institution, Shock Trau  5. Social Security Number	ma Cen	(In yrs. last birthday)	4b. City, Town, or I BCU If Under 1 Year	ltimure		. County of Deat	h N/A
	Funeral Director		216-54-2912 Usual Residence of Decedent	1□M 20 F	57 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, Year,	7	untry)
	the Marylar 28a-f show	Director	10a. State 10b. County  10e. Street and Number	NH	10c. City, Town or Lo	Baltin	nore			10d. Inside City Limits 1 ☐ res 2 ☐ No
	hours after death with the Maryland tural', or Items 23a or 28a-1 show al Exardinal rust be nuilified at	Funerai Dir	338 South	12. Was Decedent E	ver in U.S. 13.1	10f. Zip Code  A  Was Decedent of His f Yes, specify Cuban	1330		tizen of What Co	ncan Indian,
9600	nours after ural', or Ite	by	1 ☑ Never Married 2 ☐ Marri 3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	5	1 ☐ Yes 2 11 H6	Specify:		Black, White	/hite
21215-0036	i within 72 jiene. r than "nai ir e M. dic	Completed	15. Decedent' (Specify only highes  Elementary/Secondary (0-12)		(Give	dent's Usual Occupat kind of work done du DO NOT use retired)	tion uring most of workin	16b. K	(ind of Business/	·
Maryland 2	should be filed nd Mental Hygid marked other imatic event, II	To Be C	17. Father's Name (First, Middle, L.	Blaz	auski		18. Mother's Name	(First, Middle, Maider		
	1 and 2 Health a em 27 is ther trau		19a. Informant's Name/Relationsh  Arguerite  20a. Method of Disposition	ip (Type, Print)  Hockett	19b. Mailir  5 36  20b. Place of Dispo	ng Address (Street ar	ot Pl	Ba Ho,	or Town, State, Z	31221
Baltimore	t. Page rtment o rtant: If njury or		1 Burial 2 Deremation  4 Donation 5 Other (Sp.	ecify)	Metro	natory or other place	x4 4-3	0-05 B	alto	MD
Ba	Depa Depa Impo any is		23a. Part Lenjer the disease, or shock, or heart failure. List of	complications that caused to ship one cause on each line	he death. Do not ent	[AM 123	Midual	respiratory arrest,	Dessuf,	PA 18434 Approximate Interval Between
	Pnysician /Medical Examiner	d .	Immediate Cause (Final disease or condition resulting in death)	aHe Mu Due to (or as a	consequence of):	Shock	I	h'/.	4_	Onset and Death
7	100	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. ue to (xxxs a	con vuence of):	wnst	Lacera	Почен	-13	5 days
8760,	ate be executed hysician and he burial-transit	lical Exa	that initiated events resulting in death) Last	C. Due to (or as a	consequence of):		OUN APPR	OVED BY MEDICAL EXAM	MER	
Вох 68	eath certific attending pl for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome o 1 □ Live birth 2 4 □ Pregnant at ti	Fetal death 3	Ectopic pregnancy Other (specify)	ERTIFICA		23d. Date of deli Month	v <i>e</i> ry Day Year
, P.O.	that the died by the detached		1  Yes 2 No 9 Unknow/.	9□ Unknown			n in Part I.	23e. Did tobacco	use contribute to	the cause of death?
cords	law requires that the as been signed by th 2 should be detache	ompieted by						1 ☐ Yes 2 24a. Was an		obably 4 Unknown
Vital Records,	The ate h page	e C	25. Was case referred to medical				26. Place of Death	autopsy performed?  1 Yes 2 No	prior to c	ompletion of cause of
o	G S	n: To B	examiner? 1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury	t 2 ER/Outpatien 28b. Time of Year) Injury	t 3 DOA Other 28c. Injury a Work?	4   Nursing Holl	ne 5 Residence 8d. Describe how injur		rify)
Division	ten feati for: the	Certification:	2 Accident investig 3 Suicide 6 Could n 4 Homicide determine	ation 460 ot be 28e. Place of niur building, etc.	y - At home, farm, stre (Specify)	M 1□Ye	es 2 No	8f. Location (Street an City or Town, State	)	ral Route Number,
۵	To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by	edical Ce	29a. Certifier 1 Certifying (Check only one) 2 Medical E	Physician: To the best of examiner: On the basis of early manner state	my knowledge, death	occurred at the time restigation, in my opin	e, date and place, a nion, death occurre	nd due to the cause(s) d at the time, date and	and manner as	Balto, WD stated. to the cause(s)
	To the To the comple	Me	29b. Signature and title of certifier	und marinor state	>	29c. License		29d. Da	te signed (Month	
	3		30. Name and address of person v	the completed cause of dea	ath (Item 23a) (Type,	Print) Me Stree		ulto. Mi	23/05	
	Sta Registr		31. Date filed (Month, Pay, Year)  APR 2.8	2005 32 Registrar	's Signature	Who will	1 06	min, mi	1 -121	

			State of Maryla				-	•	
			For State Registrar	Cer	rtificate of E	Death		No. 2005	14371
	Physicia		1. Decedent's Name (First, Middle, Last) Annie Pecolia Brown				2. Date of Death Month Apr. 24,	Day Year 2005	3. Time of Death 9:45A
	/Medic Examin		4a. Facility Name (If not institution, give street and number) Future Care- Old Court		4b. City, Town, or Randall	Location of Death	ADI.Z4,	4c. County of Deal Baltin	
	Funeral Director		5. Social Security Number 2 1 8 − 2 2 − 5 4 7 3  0. Sex 1	s. last birthday) Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day, You Oct. 1, 1	9. Birt 923 N. Ca	hplace (State or Foreign untry) erolina
	Maryland -! show	tor		Wood	cation lawn				10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	or 28a	Direc	10e. Street and Number		10f. Zip Code	21 207	10g.	Citizen of What Co	untry?
	ns 23e	erai	2011 Royal Garden Drive  11. Marital Status  12. Was Decedent Ever in Armed Forces?	U.S. 13. 1	Was Decedent of His	21207	cify Yes or No-	14. Race - Ame	nican Indian,
9800	within 72 hours after death with the Maryland ene. than "netural", or Items 23e or 28a-f show he Medical Examinar must be notified at	Completed by Funeral Director	Armed Forces?  1 □ Never Married 2 □ Married  1 □ Yes 2 □ Notes  1 □ Yes 2 □ Notes  1 □ Yes 3 □ Notes  1 □ Yes 4 □ Notes  1 □ Yes 4 □ Notes  1 □ Yes 5 □ Notes  1 □	į	f Yes, specify Cubar 1 ☐ Yes 2 ☐ No	spanic Origin? (Spen, Mexican, Puerto F Specify:	Rican, etc.)	Black, Whit	e, etc. Black
1215-(	within 72 h ene. than "netu	mpiete	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  9th grade  College (1-4or 5+)	(Give	dent's Usual Occupa kind of work done d DO NOT use retired) ewife	ition luring most of workin 	ng	b. Kind of Business n Home	Industry
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygione. Importent: If item 27 is marked other than "netural", or Items 23e or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at Once.	To Be Co	17. Father's Name (First, Middle, Last) Charles Lee Proctor			18. Mother's Name Margare			
, Mary	and 2 shou alth and M 127 is man er traumai		19a. Informant's Name/Relationship (Type, Print) Regina Gayle/ Niece				Route Number, C rive Ba	ity or Town, State, 2 ltimore	Md 21207
Baltimore,	Pages 1 and nent of He ant: If item ury or other			oudon	sition (Name of natory or other place Park Cer	netery	/05 Ba		,Maryland
Balt	permit. Departr Importe any inj		21. Signature of Funeral Service Censee	5	240 Reis	sterstow	n Rd Ba	ltimore	neral Home ,Md 21215
	Physician		23a. Part Linter the disease, or complications that caused the deshort, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition	ath. Do not ent		g, such as cardiac or	r respiratory arrest,	•	Approximate Interval Between Onset and Death
	/Medical Examiner		Due to (or as a conse	equence of):					
	suted ad ransit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that mittad events c.	equence of):				P	
,0921	icate be executed physician and s the burial-transit	icai	resulting in death) Last  Due to (or as a conse	equence of):					
O. Box 68	death certif e attending ed for use as	Completed by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 morths? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  23c. If yes, outcome of pregnant in the past 12 morths? 4 ☐ Pregnant at time of 9 ☐ Unknown	ital déath 3 □	Ectopic pregnancy Other (specify)			23d. Date of del Month	ivery Day Year
ds, P.O.	es ign be	d by Ph	Part II. Other significant conditions contributing to death but not re	-		on in Part I.		co use contribute to	the cause of death?
Records,		piete					24a. Was an autopsy	prior to	topsy findings available completion of cause of
Vital R	sicien: The law certificate has t irector, page 2 s		25. Was case referred to medical			OC Place of Parth	performed	d?// death?	2□ No
of Vit	> 0 0	To Be	examiner?  1 Ves 2 No Hospital: 1 Inpatient 2	☐ ER/Outpatier	t 3 DOA Othe	26. Place of Death		e 6 Other (Spe	cify)
o uo	ding I. After fune		27. Manner of Death  1 Natural 5 Pending (Month, Day Year)	28b. Time of Injury	Work	at 2 ? ∕es 2 □No	8d. Describe how	injury occurred	
Division	or Attending after death. Director: Afte d in by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At building, etc. (Special Could not be determined 28e. Place of Injury - At building, etc. (Special Could not be determined 28e. Place of Injury - At building, etc. (Special Could not be determined 28e. Place of Injury - At building, etc.)	home, farm, str cify)			8f. Location (Stree City or Town, S	t and Number or Ru State)	ıral Route Number,
	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	edical C	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my k 2 Medical Examiner: On the basis of examinand manner stated.	nowledge, death nation and/or in	occurred at the time vestigation, in my op	e, date and place, a inion, death occurre	nd due to the caus d at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)
	Vithir To th	M	29b. Signature and title of certifier		29c. License			Date signed (Monti	
A	/	1	30. Name and address of person who completed cause of death (It	em 23a) (Tyne.	Print)	722		RIL 28	
_	5		CEONARD RICHARDSON 5602 B	BALTIMOR	E NATIONA	IL PILE A	603 BAC	TIMORE M	021228
	Sta Registr		31. Date filed (Month, Day, Year) APR 2 8 2005		artis)		,		

			1- State of Maryland / Department of Health a Certificate of Death		Hygiene	05 11.272
	Physicia	an	1. Decedent's Name (First, Middle, Last)	2. Date Mont	of Death Day	Year 3. Time of Death C
	/Medic	al	GEORGE BRUTON	Apr		005 4:20 M
	Examin	er	4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location or Roll to City, Town, or Roll to City, Town, or Roll to City, T	of Death \	4c. County	of Death
	Funeral		5. Social Security Number Sex 7. Age (In yrs. last birthday) If Under Vear If Under	24 Hrs. 8. Date	of Birth	Birthplace (State or Foreign Country)
	Director		212-34-3451 1X M 2 F 68 Yrs. Months Days Hours		th, Day, Year) 30–1936	Country) MD
_	pu .		Usual Residence of Decedent           10a. State         10b. County         10c. City, Town or Location			10d. Inside City Limits
	Aaryle f sho	ō				1XXYes 2 No
	28a-	rect	MD         BALTIMORE           10e. Street and Number         10f. Zip Code		10g. Citizen of	What Country?
	h with	al Di	701 N. ARLINGTON AVENUE APT. 304 21217		USA	
	ems serving	Funeral Director	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent of Hispanic Orin If Yes, specify Cuban, Mexican	igin? (Specify Yes		e - American Indian, ck, White, etc.
36	or It	by Fu	1 Never Married 2 Married 1 XX Yes 2 No If Yes, Give 1 No Specify:		Specif	
90	hour: tural' al Ex	q pa	3 Widowed 4 Divorced Year or Dates:  15. Decedent's Education 16a. Decedent's Usual Occupation			BLACK
21215-0036	in 72 n "na n "na	Completed	(Specify only highest grade completed) (Give kind of work done during most	st of working	160. Kirid of B	usiness/Industry
212	d with giene er tha	mo	Elementary/Secondary (0-12) College (1-4or 5+)  10 ENVIRONMENTAL ENGIN	NEER	STATE	OF MARYLAND
덛	be file tal Hy d othe	Be (	17. Father's Name (First, Middle, Last)  18. Mother	er's Name (First, M	fiddle, Maiden Suman	ne)
yla	Mend I Me	P_		AULINE IS		
Maryland	is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "naturat", or liems 23a or 28a-f show other traumatic event, the Madical Examinat must be notified at		19a. Informant's Name/Relationship (Type, Print)  SYLVIA L. JORDAN/SISTER  19b. Mailing Address (Street and Number 8996 BUCKSKIN CT.		Number, City or Town, A, MARYLAN	
ē,	s 1 an Heal Item 2 other		20a. Method of Disposition 20b. Place of Disposition (Name of	Date		City or Town, State
Baltimore,	permit. Pages 1 Department of H Important: If Ite any injury or ot once.		1 □ Burial 2 □ Cremation 3 □ Removal from State  '4 □ Donation 5 □ Other (Specify)  **Commetery, crematory or other place)  KING MEMORIAL PARK	5-2-05	BAT.TTM(	ORE, MARYLAND
alti	permit. DepartmImporta Importa any inju		21. Signature of Funeral Service Licensee 22. Name and Address of Facilit			SONS F.H., INC.
	80 E 5 8		ames a. Morton 1701-31 LAURENS	S ST. BAI	TIMORE, MA	ARYLAND 21217
•	rnysician /Medical Examiner		resulting in death)  Due to (or as a consequence of):	morr	Lage	Approximate Interval Between Onset and Death
8760,	sate be executed oblysician and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last  Due to (or as a consequence of):  C.  Due to (or as a consequence of):			
.O. Box 68760	The law requires that the death certificate tte has been signed by the attending phys age 2 should be detached for use as the	Physician/Med	IFFEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes   2   No   9   Unknown   Unknown   Unknown   23c. If yes, outcome of pregnancy   1   Live birth   2   Fetal death   3   Ectopic pregnancy   5   Other (specify)   1   Unknown   1   Unknown			te of delivery nnth Day Year
) q	res that the digned by the be detached	by Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	. 23ө.	Did tobacco use cont	ribute to the cause of death?
rds	v require: been sig should b		anoxic encephalopathy		1 ☐ Yes 2 ☐ No	3 Probably 4 Unknown
o ( )	e law requ has been je 2 should	Completed	Colonary arternalises	24a.	Was an 24b.	Were autopsy findings available prior to completion of cause of
W E	The ate h	Com			performed?	death?  1 □ Yes 2 □ No
Vital	Physician: Th r this certificate ral director, pag	Be	examiner?	of Death (Check		
6	Physi this o	. To			Residence 6 Oth	
	ding Phys h. After this funeral di	tion	Natural 5 Pending (Month, Day Year) Injury Work?		cribe how injury occur	ed
Division	Attendir death.	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office	28f. Local	tion (Street and Numb	er or Rural Route Number,
3 <b>á</b>	s afte	Cert	4 ☐ Homicide determined building, etc. (Specify)	City	or Town, State)	
2	To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate h. completely filled in by the funeral director, page	Medical (	29a. Certifier (Check only one)  Medicel Examiner: On the basis of examination and/or investigation, in my opinion, deal and manner stated.	d place, and due to th occurred at the	o the cause(s) and ma time, date and place,	unner as stated. and due to the cause(s)
	To the within 2 To the comple	Mec	one) and manner stated.  29b. Signature and title of certifier 29c. License number		29d. Date signe	d (Month, Day, Year)
	- 5 - 0		Manuel Janapan 03306	< \	Apr. 1	27 2005
			30 Name and address of person who completed cause of death (Item 23a) (Type, Print)	<u> </u>	7	0
9	1		Deanine Joundars Stagner H	tealt	hoore	Datimore
	Sta		Mate filed (Month, Day, Year)  32. Registrar's Signature			
D111	Registr		APR 2 8 2005			
DAI	wii i/ NeV 1/2	001	ORIGINAL			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] [] 5 For State Registrer Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Day 2005 Month April Physician 25. 3:30 P M Elbert Ellsworth Bane /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Joseph Richie Hospice Baltimore If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) Funeral Months Days Hours Min. 1**X** MM 2 ☐ F 216-36-2765 Director 64 1Ó. 1940 Pennsylvania Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28e-f shov traumatic evant, the Medical Examiners ust be notified at N/A Baltimore Maryland ¥∰Yes 2 No Director 10f. Zip Code 21211 10e. Street and Number 10g. Citizen of What Country? ō 4015 Falls Road USA Funeral or Itams Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 72 hours after 1 ☐ Yes 2**XX**No If Yes, Give Year or Dates: 1 Never Married 2 Married so White Maryland 21215-0036 1 Yes 2 No Specify: à 3 Widowed 4 Divorced "netural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry d 2 should be filed within 7; th and Mental Hygiene. 7 Is marked other than "ne Elementary/Secondary (0-12) College (1-4or 5+) Salesperson Greenspring Dairy 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Unknown Unknown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 Department of Health at Importent: If item 27 Is any injury or other trau once. Emma Louise Bane 4015 Falls Road, Baltimore, Maryland 21211 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Meadowridge Memorial 4/29/2005 Elkridge, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature A Funeral Service Licens 22. Name and Address of Facility Burgee-Henss-Seitz Funeral Home, Inc. 3631 Falls Road, Baltimore, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or feart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): that the death certificate be executed Due to (or as a consequence of): Completed by Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4 Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death 1 ☐ Yes 2 ☐ No 3/☐ Probably 4 nknown Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No Be 25. Was case referred to edical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 1 🗌 Yes 6 Other (Specify) Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manne of Death 28b. Time of 28d. Describe how injury occurred Fo tha Hospital or Attanding 5 Pending 1 Natural investigation 1 ☐ Yes 2 ☐ No 2 🗌 Accident Diractor: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by determined 4 Homicide within 24 hours To the Funaral 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. ical 29a, Certifier 29c. License number 29b. Signature and title of cert 30. 1 State Registrar

Director		231-44-	0090		09	1.0.			MA.
pu 🔉		Usual Residence o 10a. State	Decedent 10b. County		10c Cit	y, Town or Loca	tion		
shor	7				100.01				
he M	ecto	MD.  10e. Street and Nu	N/A			BALTIM		-de	
with the or it	ä			V OMPTI	-m		10f. Zip Co		
s 23	erai	805 S	. GRUND	Y STREE		S 10 146		1224	2 (Consitu
er de litem	un.	11. Marital Status	ind 20 Married	Armed For	ces?	If Y	es, specify	t of Hispanic Origin Cuban, Mexican, P	uerto Rica
Baltimore, Maryland 21215-0036  permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene.  Department of Heath and Mental Hygiene important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Modeal Examiner must be notified at once.	Be Completed by Funeral Director	3 Widowed	ied 2 Married 4 Divorced	1 □ Yes If Yes, Give Year or Da	9	10	∐Yes 2 <mark>X</mark>	No Specify:	
72 hc	letec	(Spe	15. Decedent's Ed	ducation ade completed)		16a. Deceder (Give kii		done during most of	f working
withir lene. than	dwo	Elementary/Seco	ondary (0-12)	College (1-	4or 5+)	NURS		etilea)	
filed Hyg other	C	17. Father's Name	(First, Middle, Last,	)				18. Mother's	Name (Fir
fental rked tic ev	To B	PATRIC	K GREA	LLY				MA	RY :
shou and N		19a. Informant's N	ame/Relationship (	Type, Print)		19b. Mailing	Address (S	treet and Number of	or Rural Ro
and 2 salth a n 27 i er tra		LAURENC	E BAXLE	Y/ SON			. GR		REET
of He of He fitem		20a. Method of Dis		Domoval from S	1 /	Place of Disposit cometery, crema	ion (Name tory or othe	of or place)	Date
Pages nent of h ant: If its ury or of			☐ Cremation 3 ☐ 5 ☐ Other (Specil		ROS	EWOOD	MEMO	RIAL 4	/28/
permit. Departrr importa any inju		21. Signature of F	uneral Service Lice	nsee	1	22. I	Name and A	Address of Facility & ZEILE	D TN
89789		-		593	and the	70		CONKLI	
		23a. Part1. Enter	the disease, or com art failure. List only	plications that ca	used the deat ich line.	h. Do not enter	the mode o	of dying, such as ca	rdiac or re
Physician		Immediate Cause disease or condition	(Final			1.1	00	Chour	
/Medical		resulting in death)		Due to (c	or as a conseq	uence of):	1 1	Charles	
Examiner									
	Je.	Sequentially list co	onditions, nmediate	Due to (d	or as a conseq	uence of):			
cuted id ansit	Examiner	Cause (Disease of that initiated event	injury s	c.					
The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	EX	resulting in death)	Last	Due to (d	or as a conseq	uence of):			
ite be nysici	by Physician/Medical			d					
ng ph as t	Med	IF FEMALE:							
th ce tendii r use	an/N	23b. Was deceder		23c. If yes, outo	come of pregnanth 2 Feta		ctopic pregr	nancv	
deal	sicis	in the past 12	No		ant at time of d		Other (speci		
at the by the	hy	9 Unknown							
gned goded	by	Part II. Other signi	ficant conditions	contributing to de	ath but not res	ulting in the und	erlying caus	se given in Part I.	
en si	ed								-
awre s ber 2 sho	ompleted								
The I									_
an: tifica tor, p	Be C	25. Was case refe	rred to medical					26. Place of	Death (C)
ysici s cer direc	0	examiner? 1 ☐ Yes 2 ☑	Mo	Hospital: 1   Ir	patient 2	ER/Outpatient	3□ DOA	Cther: 4 ☐ Nursi	
g Phy er thi	l H	27. Manner of Dea			f Injury h, Day Year)	28b. Time of		Injury at Work?	28d.
th. : Afte	tio	1 Natural 2 Accident	5 Pending investigatio		n, Day rear)	Injury	М	work? 1 ☐ Yes 2 ☐ No	
o the Hospital or Attending Physician: The thin 24 hours after death.  thin Experies Director: After this certificate or the Funeral Director: After this certificate or the tuneral director, page 100 pt.	Certification;	3 Suicide	6 Could not be determined	28e. Place	of Injury - At h	ome, farm, stree y)	et, factory, o	ffice	28f.
pital ours a eral C	S	20a Codifier	1 Cortifuina Di	hyginian: To the	heat of my lim	undarden decit		the time data and	alana ard
Hos 24 hc Fun	Medical	29a. Certifier (Check only one)	2 ☐ Medical Exa	miner: On the ba and mann	sis of examina	wiedge, death o ition and/or inve	stigation, in	the time, date and p my opinion, death	occurred a
thin the the the the the the the the the the	Me	29b. Signature and	title of certifier				29c. L	icense number	

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** 2115 PM 2005 ANNA BAXLEY APRIL 22 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** STELLA MARIS HOSPICE AT MERCY BALTIMORE If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Min. | MARCH | 8, 1916 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Funeral 1□M 20F MASSACHUSETTS 10d. Inside City Limits 1XYes 2 No 10g. Citizen of What Country? U.S.A. Yes or No- Race - American Indian, Black, White, etc. Specify: WHITE 16b. Kind of Business/Industry MEDICAL rst, Middle, Maiden Sumame)  $\mathtt{LALLY}$ ute Number, City or Town, State, Zip Code) BALTIMORE, MD. 21224 20c. Location - City or Town, State 05 VIRGINIA BEACH, VA FUNERAL HOME TREET, BALTIMORE, MD Approximate Interval Between Onset and Death spiratory arrest, 23d. Date of delivery Month Year Day 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed2 1 Yes 2 No hack only one) 5 ☐ Residence 6 ☐Other (Specify) Describe how injury occurred Location (Street and Number or Rural Route Number, City or Town, State) due to the cause(s) and manner as stated.

It the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 2002 740854 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore Vivoc 31. Date filed (Month, Day, Year) State APR 2 8 2005

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Registrar DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death April **Physician** 4 10 PM **BACH** STUART 23, 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Citz Beltimore N/A Hospital Sina ot Beltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 09/01/1954 6. Sex 1Ø M 2 ☐ F Birthplace (State or Foreign Country)
 MD **Funeral** Months Days Hours Min. MD 50 217-62-1663 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show traumatic event, the Madical Examiner must be notified at 1**X** Yes 2 ☐ No Completed by Funeral Director MD BALTIMORE N/A 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or items 23a 21215 U.S.A. 2500 BELVEDERE AVENUE 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ဤ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc iiled within 72 hours after 1 Never Married 2 ☐ Married WHITE Baltimore, Maryland 21215-0036 1 Tes 2 No Specify: 3 ☐ Widowed 4 Divorced "naturel" 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) and Mental Hygiene. College (1-4or 5+) CAB DRIVER TAXI (TRANSPORTATION) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be should be fund Mental I BACH TREUBICZ HELEN MORRIS John Pages 1 and 2 shring pages 1 and 2 shring postument of Heelth important: If tier any injury r 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SAMUEL BACH / BROTHER REISTERSTOWN, MD 21136 33 BON OAK COURT 20a. Method of Disposition
1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 04/27/2005 | BALTIMORE, MD HEBREW FREE BURIAL \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Endoweditis Priysician day disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** leiastatic Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury Examiner The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy be detached for in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Yinknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Yes or Attanding Physicien: 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Injury at Work? After Natural 5 Pending s after death. 1 ☐ Yes 2 ☐ No 2 Accident investigation the 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide within 24 hours a

To the Funerel I

completely filled To the Hospitel Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year) Q. Bradeusleeite 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sina BRADAUSKAITE 31. Date filed (Month, Day, Year) State APR 2 8 2005 Registrar

tatient Known as Van Lear Blaney ■ Baltimore, Maryland 21215-0036 Division of Vital Records. P.O. Box 68760. 239

		Please Type or Print in Black Indelible Ink. Ensure All		
		State of Maryland / Department of Health and Me 1- State Pegistrar Amend Item 23a per Dr., G842,047,8705 dhb Certificate of Death	ntal Hygie Reg.	
Physici	an		2. Date of Death Month	Day Year 3. Time of Death
/Medic	al	4a. Facility Name (If not institution, give street and number)  4 b. City, Town, or Location of Death	pril	12 2005 11 2 40 P M 4c. County of Death
Examin	er	Sinai Hospital of Baltimore Baltimore City		N/A
Funeral Director		5. Social Security Number 6. Sex 1 Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8 Yrs. Wonths Days Hours Min.	Date of Birth (Month, Day, Ye	9. Birthplace (State or Foreign Country)
yland how		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits
he Mar 28a-f si	Director	MD NA Baltimore		1 OV Yes 2 □ No
burs after deeth with the Marylan ei', or items 23a or 28a-f show Examinar must be notified at	al Dir	2426 II). Coldspirm Lane.	10g.	. Citizen of What Country?
er dest items ?	Funeral	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent of Hispanic Origin? (Specific Specific Coban, Mexican, Puerto Richard Status)	fy Yes or No- can, etc.)	14. Race - American Indian, Black, White, etc.
	by	1 Nover Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates:		Specify: BACK
in 72 hours "naturel", tedical Est	olete	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done during most of working  16b. Do NOT use retired)	168	b. Kind of Business/Industry
be filed within 72 hatel Hygiene. Id other then "natuevent, the Medical	Completed	(Specify only highest grade completed)  Flamentary/Secondary (0-12)  College (1-4or 54)  College (1-4or 54)  College (1-4or 54)  College (1-4or 54)  College (1-4or 54)		Home
d be fill entai H ked oth c even	o Be	17. Father's Name (First, Middle, Last)  18. Mother's Name (I  18.	First, Middle, Mai	den Sumame)
2 should and Mer is marks sumatic	<b> -</b>	19a. Info ant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number of Ruzal F	Route Number, C.	1
1 and Health Health tem 27		11 legin blaney, JR. Son) 316 Woodsprum Drive 20a. Method of Disposition (Name of Date 20b. Place Observed Date 20b. Place 20b. Place 20b. Plac	e Atom	Con ND 2/09
Pages nent of ant: If it		1 M Burial 2 Cremation 3 Removal from State  1 Donation 5 Other (Specify)  Carrison Forest 4-20	-05 (	una Mulla MD
permit. Pages 1 and 2 should be filed within Department of Health and Mandal Hygiene. Importent: If item 27 is marked other than eny injury or other treumatic event, Ir a Magnes.		21. Signature of Funeral Service Licenspe  22. Name and Address of Facility  23. Name and Address of Facility  24. Name and Address of Facility  25. Name and Address of Facility  26. Name and Address of Facility	TO LO	tour, MD 21132
		23a. Part1. Enter the dease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or r shock, or heart failure. List only one cause on each line.		
Physician /Medical		Immediate Cause (Final disease or condition resulting in death)  Aspiration Pneumon	ia	Onset and Death
Examiner		Due to (or as a consequence of):  Metastate Breast Cancer  Sequentially list conditions,		5 years
uted 1 Insit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		
e executed lian and urial-transit		that initiated events c. resulting in death) Last Due to (or as a consequence of);		
and continued be executed attending physician and for use as the burial-transit	edlca	d		
ath certi	an/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy		23d. Date of delivery
t the d	Physician/Medical	1 □ Yes 2 □ No 9 □ Unknown 9 □ Unknown 5 □ Other (specify)		Month Day Year
ries that signed to	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  Steroid dependant Rheumatoid Arthribs		co use contribute to the cause of death?
aw require as been si 2 should b	Completed	score in dependant knehmacula minning	1 ☐ Yes 24a. Was an	2 1 On 3 Probably 4 Unknown  24b. Were autopsy findings available
The la	Comp		autopsy performed 1 ☐ Yes 2 ☑	prior to completion of cause of death?
Physicien: The la this certificate ha ral director, page 2	o Be	25. Was case referred to medical examiner?  1 Yes 2 Mo  Hospital: 1 Mopatient 2 ER/Outpatient 3 DOA  Other: 4 Nursing Home		
ng Phy fter this	-	Of Manager Death	5 ☐ Residence d. Describe how i	e 6 Other (Specify)
death. ctor: A	ilcati	2 Accident investigation 3 Suicide 6 Could not be 388 Bloom of Injury. At home for which (i)	Location (Stree	t and Number or Rural Route Number,
itel or A	Certification;	4 ☐ Homicide building, etc. (Specify)	City or Town, S	itate)
To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certifical completely filled in by the funeral director;	edical	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, an	d due to the caus at the time, date	e(s) and manner as stated. and place, and due to the cause(s)
within To th	Ñ.	29b. Signature and title of certifier 29c. License number		Date signed (Month, Day, Year)
11		Shalini B MD RES - 000  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	Ap	ril 12,2005 timore.
4		SHALINI BOYAPATI MD Cinai Harrital	of Bal	timore.
Sta Registr		31. Date filed (Month, Day, Year)  APR 2 1 2005  32 legistrar's Signature	Ü	
DHMH 17 Rev 1/20	001			

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** April 25, 2005 Year 6:22 Рм Ernest Samuel Carson /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Arbutus Baltimore 5 Social Security Number 8. Date of Birth Sept. Day, Year) 1930 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birtholace (State or Foreign Country) Maryland **Funeral** 1 M 2 □ F Days Hours 74 Director 213-28-3218 Yrs. Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location Itam 27 is marked other than "natural", or Itama 23a or 28a-f show other traumatic evant, the Madical Expedition must be natified at 10d. Inside City Limits Maryland Baltimore 1 ☐ Yes 2 ☐ No Director Arbutus Street and Number 10f Zin Code 10g. Citizen of What Country? with 1012 Grovehill Rd. 21227 U. S. A. Funeral death 12. Was Decedent Ever in U.S.
Armed Forces? 1951—
If Yes, Give Year or Dates: 1953 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, 72 hours after Black, White, etc. 1 Never Married 2 N Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No þ Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry d 2 should be filed within 7% th and Mental Hygiene. 7 Is marked other than "ne Elementary/Secondary (0-12) College (1-4or 5+) Public Services 12 Police Officer 17. Father's Name (First, Middle, Last)
Samuel Cook Carson 18. Mother's Name (First, Middle, Maiden Sumame) Be Nellie K. Worth 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 s nent of Health an ant: If Itam 27 Is Rosemarie Carson, wife 1012 Grovehill Rd. Arbutus, MD. 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State ₩ Burial 2 Cremation 3 Removal from State Oaklawn Cemetery injury or permit. Page Department of Important: If any injury or once. 04-30-05 Dundalk, MD \* 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Ambrose Funeral Home, Inc. 21. Signature of Funeral Service Licenses Stekus 1328 Sulphur Spring Rd. Arbutus, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Widely **Physician** COLON CANCER JEAR disease or condition resulting in death) METASTATIC /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine burial-transit Due to (or as a consequence of): ng physician a as the burial-Records, P.O. Box 68760 Physician/Medical attending IF FEMALE: esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death Dav Year 5 Other (specify) the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? levico Division of Vital 2 10 1 Yes 2 Mo 1 Yes To the Hospital or Attending Phyaician: within 24 hours after death.

To the Funaral Diractor: After this certified Be referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 Yes 2 10 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manne of Death 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) D16200 ed cause of death (Item 23a) (Type, Print) MD 720-C MAIDEN Choice hA N.M. MACHIRAN 31. Date filed (Month, Day, Year) State APR 2 8 2005 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day 25 **Physician** 10:30 at 2005 Jerome H. Cunningham April /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner 1573 Curtis Avenue Glen Burnie <u>Anne Arundel</u> 8. Date of Birth (Month, Dev. Year) Mar 8,1927 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country)
 MD 1 ₹M 2 □ F 216-20-4374 78 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Anne Arundel Glen Burnie

10f. Zip Code

21060

10g. Citizen of What Country?

U.S.A.

Director iral, or items 23a or 28a-f show Lexamber must be notified at Directo

10e. Street and Number

1573 Curtis Avenue

**Funeral** 

Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Heatth and Mental Hygiene. ant of Heatth and Mental Hygiene. and I tem 27 is marked other than "natural", or Items 23s or 28s-f show

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

attending physician and for use as the burial-transit within 24 hours after death.

To the Funeral Director: After th completely filled in by the funeral

To the Hospital or Attanding Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

by Funer	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ever in U.S. Amped Forces? 1 △ Yes 2 ☐ No	13. Was Decedent of Hispanic Ori If Yes, specify Cuban, Mexican		14. Rece - Am Black, Whi	
by	3 XWidowed 4 ☐ Divorced	If Yes, Give Year or Dates:	1 ☐ Yes 2 X No Specify:		Specify:	white
Be Completed	15. Decedent's Ed (Specify only highest gra		5a. Decedent's Usual Occupation (Give kind of work done during mos life. DO NOT use retired)	st of working	. Kind of Business	s/Industry
mpi	Elementary/Secondary (0-12)	College (1-4or 5+)			T T C	
S	17. Father's Name (First, Middle, Last)	4	Police Officer	er's Name (First, Middle, Maid	Law Enfo	orcement
Be	Peter Joseph Cur			bara Mary Zan		
٦	19a. Informant's Name/Relationship (		9b. Mailing Address (Street and Number			Zin Code)
			1573 Curtis Avenu		-	
	20a. Method of Disposition		of Disposition (Name of stery, crematory or other place)		. Location - City or	
	1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specification)	Glen	Haven Mem. Park A	pr.29,2005 G	len Burni	ie, MD
	21. Signature of Funeral Service Licer	MO1364	22. Name and Address of Facili	singleton Function S.W., Glen Bu	uneral Ho urnie, M	ome P.A. D 21061
	23a. Part1. Enter the disease, or com shock, or heart failure. List only fmmediate Cause (Final disease or condition	plications that caused the death. In one cause on each line.  A Herry Roll	o not enter the mode of dying, such as	cardiac or respiratory arrest,		Approximate Interval Between Onset and Death
	resulting in death)	Due to (or as a consequence				years
aminer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence c. Chreme	Abeline fri	lung Dir	lace	years
Completed by Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	Due to (or as a consequence d	ath 3□Ectopic pregnancy		23d. Date of de Month	elivery Day Year
hys	9 □ Unknown	9□ Unknown				
d by P	Part II. Other significant conditions of	contributing to death but not resulting	g in the underlying cause given in Part I			to the cause of death?  Probably 4 Unknown
mplete	old cer	rlingvarenlen	accident	24a. Was an autopsy performed	prior to death?	
Ü	25. Was case referred to medical		00.81	1□ Yes 2	No 1 ☐ Ye	s 2 No
To Be	examiner?  1 \( \text{Yes} \) 2 \( \text{No} \)	Hospitaf: 1 ☐ Inpatient 2 ☐ ERV		e of Death <i>(Check only one)</i> ursing Home 5 <b>X</b> Residence	e 6 DOther (See	acrés)
tion: T	27. Manner of Death  1 Natural 5 Pending  2 Accident Investigation	28a. Date of Injury (Month, Day Yeer) 28i	o. Time of linjury at Work?  M 1 □ Yes 2 □	28d. escribe how i	infury occurred	ecny)
ertifica	3 Suicide 6 Could not be determined		farm, street, factory, office	28f. Location (Stree City or Town, S	t and Number or Ritate)	Rural Route Number,
Medical Certification:	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	nysician: To the best of my knowled miner: On the basis of examination and manner stated.	dge, death occurred at the time, date ar and/or investigation, in my opinion, dea	nd place, and due to the caus ath occurred at the time, date	e(s) and manner a and place, and du	s stated. e to the cause(s)
Me	29b. Signature and title of certifier	<b>n</b> *	29c. License number	29d.	Date signed (Mon	ith, Day, Year)
	Stevaen D	- lamnon	0003891	2	04/25	105-

State Registrar SALVACION

31. Date filed (Month, Day, Year) APR 2 8

78 45 Oakword

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2005

Raminez

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend Item I per phys 2842 4-28-05 vt.

State of Manual of Department of Health and Mental Hygiene

	- Т	_ State					d Mental I	i iy giloi	000	
	1	Registrar  . Decedent's Name (First, Middle, Las	e1	Ce	rilicate	of Death	2. Date o	Reg. N	10.2005	3. Time of Death
Physician /Medical		LURIL CURTIS					Month	/ [	2005	1238 p.N
Examiner	. i	a. Facility Name (If not institution, give Maryland Gener	street and number)	tal	4b. City, Tov Balt	more C	rty	4	tc. County of Death	1
Funeral Director		216 94 4511	7. Age ☐ M 2 🛣 F	(In yrs. last birthday) 38 Yrs.	If Under 1 Y Months D		Hrs. 8. Date of (Month) JULY	. Day, Yea	9. Birth Cou 1966 MARY	place (State or Foreig ntry) (LAND
3	-	Jsual Residence of Decedent  0a. State 10b. County		10c. City, Town or Lo	ocation	<u> </u>				10d. Inside City Limit
naturel, or liems 23s.or 28e-f show disal Examination motified at eted by Funeral Director		MD N/A		BALTIMORE						t <b>Y</b> Yes 2 □ No
or 28 or 28 or 28	1	0e. Street and Number			10f. Zip Co	ode		10g. 0	Citizen of What Cou	ntry?
23E.		1211 N. ENSOR STR	EET		21202			Ü	J.S.A.	
Department of Health and Mental Hygiene "naturel", or Items 23s. or 28e-f show Importent: If item 27 is marked other then "naturel", or Items 27 is marked other then well on the result of the Medical Examenation of the same once.  To Be Completed by Funeral Director	1	Marital Status     Never Married 2     Married 3 □ Widowed 4 □ Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 X No If Yes, Give		Was Decedent if Yes, specify 1 ☐ Yes 2X	t of Hispanic Origin Cuban, Mexican, P No Specify:	? (Specify Yes o uerto Rican, etc.	r No- .)	14. Race - Ameri Black, White, Specify:	etc.
turel tal Ex		15. Decedent's Ed	Year or Dates:	16a Dece	dent's Usual O	Occupation		16h	Kind of Business/Ir	
ygiene. ner then "nature it, the Wedical I	_	(Specify only highest grad		(Give	kind of work a DO NOT use r	done during most of etired)	working	100.	Tana or basinessin	ioustry
and mental Hyglene. Is marked other then eumatic event, Th.M. To Be Comp			YEAR	,	RESOUR	CES		HOT	EL	
arked otherstice event		7. Father's Name (First, Middle, Last)					Name (First, Mic		,	
natic and To		CORNELL GREENE					E. SAU			
em 27 Is m ther treum		19a. Informant's Name/Relationship (7 CHRISTOPHER PATTE		4002	AYRDAL	E AVE. BA	LTIMORE		y or Town, State, Zij YLAND 212	
ant: If iter iry or oth	2	Oa. Method of Disposition 1 □ Burial 2 🛣 Cremation 3 □	Removal from State		matory`or othe	r place)	Date		Location - City or T	
jury o		*4 Donation 5 ☐ Other (Specify	)	/				100		RE, MARYLA
Importent: If eny injury or once.	1	Inature of Funeral Service Licens	2 The	rugg 1	2. Name and A	ddress of Facility PRESTON S	CALVIN :	B. SC ALTIM	RUGGS FUN ORE, MARY	TERAL HOME TLAND 2121
t I		23a. Part1. Enter the disease, or comp shock, or heart failure. List only	olications that caused to one cause on each line	he death. Do not en	ter the mode of	f dying, such as car	diac or respirato	ry arrest,		Approximate Interval Between
ician		Immediate Cause (Final disease or condition	1-sche	mic (	ardie	myopa	athy			Onset and Death
ical ner	Н	resulting in death)	Due to (or as a	consequence of):	100+	myope Failure	,			
<b>33</b> .		Sequentially list conditions, fany, leading to immediate	b. Conglis							
nin		cause. Enter Underlying Cause (Disease or injury	Susson	n	11118	ERYTHE	ma + a	511	2	
rial-transit Examiner		that initiated events resulting in death) Last	c. Due to (or as a	consequence of):	yus	agine	7.100 1 0		_	
the burial-transit			d							
on a o	F	F FEMALE:								
be detached for use as		23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of 1 ☐ Live birth 2	Fetal death 3	Ectopic pregn	nancy			23d. Date of deliver	ery Day Year
hed fo		1 Yes 2 100 9 Unknown	4□Pregnant at t 9□ Unknown	ime of death 5[	Other (specif	(y)			Widitii	Day 18a1
detac		Part II. Other significant conditions of	ontributing to death but	not resulting in the u	nderlying caus	e given in Part I.	23e. [	Did tobacco	use contribute to t	he cause of death?
g g							1	I □ Yes	2 □ No 3 □ Prot	pably 4 Donknow
5 0							24a. V	.÷ Mas an	24b. Were auto	ppsy findings availabl
should t							- a	utopsy erformed? es 2	prior to co death?	mpletion of cause of
2 should	-									2LI NO
2 should	1 2	25. Was case referred to medical				26. Place of	1 🗆 Yı		.0	
director, page 2 should	2	examiner?	Hospital: 1 Hipatien	t 2 ☐ ER/Outpatie	nt 3 DOA	Cthor	☐ You Death (Check or	nly one)	6 ☐Other (Specif	(y)
Il director, page 2 should  To Be Completed	2	examiner? 1 Yes 2 No  7. Manner of Death	Hospital: 1 Hopatien  28a. Date of Injury (Month, Day	28b. Time o		Cther: 4 ☐ Nursir	1 ☐ You Death (Check or ing Home 5 ☐ F	nly one) Residence		(y)
funeral director, page 2 should ilon: To Be Completed	2	examiner? 1 Yes 2 No  7. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day	28b, Time o		Cthor	1 ☐ You Death (Check or ing Home 5 ☐ F	nly one) Residence	6 □Other (Specif	iy)
funeral director, page 2 should ilon: To Be Completed	2	examiner? 1	28a. Date of Injury (Month, Day	Year) 28b. Time of Injury  y - At home, farm, st	f 28c.	Cther: 4 Nursir	Death (Check or grant of the control of the check or grant of the control of the check or grant of the check or grant of the check or grant of the check or grant of the check or grant of the check or grant of the check or grant of the check or grant of the check or grant of the check or grant of the check or grant or grant of the check of the check or grant or grant of the check or grant of the check or grant of the check or grant of the check or grant of the check or grant of the check or grant or grant of the check or grant of the check or grant or grant or grant or grant or grant or grant or grant or grant or grant or grant or grant or grant or grant or grant or grant or	nly one) Residence ibe how inj	6	
Atter ruis certificate has been s funeral director, page 2 should ilon: To Be Completed	2	examiner? 1	28a. Date of Injury (Month, Day) 28e. Place of Injury building, etc.	Year) 28b. Time of Injury  y - At home, farm, st (Specify)	f 28c. M eet, factory, of	Cther: 4 Nursin Injury at Work? 1 Yes 2 No	Death (Check or or or or or or or or or or or or or	nly one) Residence ibe how inj on (Street a	6 □Other (Specification of the control of the cont	al Route Number,
Aren tris certificate has been stronger and director, page 2 should library. To Be Completed	2	examiner? 1	28a. Date of Injury (Month, Day)  28e. Place of Injury building, etc.  28i. Place of Injury building, etc.  28i. Place of Injury building, etc.	Year) 28b. Time of Injury  y - At home, farm, st (Specify)  my knowledge, deat examination and/or in	f 28c.  M reet, factory, of	Cther: 4 Nursin	Death (Check or ing Home 5 F F 28d. Description 28f. Location City or lace, and due to	Residence ibe how inj on (Street a Town, Sta	6 □Other (Specification of the following occurred and Number or Rurate)	al Route Number,
funeral director, page 2 should	2	examiner?  1 Yes 2 No  27. Manner of Death  1 Matural 5 Pending investigation  3 Suicide 6 Could not be determined  29a. Certifier 1 Certifying Physics	28a. Date of Injury (Month, Day)  28e. Place of Injury building, etc.	Year) 28b. Time of Injury  y - At home, farm, st (Specify)  my knowledge, deat examination and/or in	f 28c.  M reet, factory, of h occurred at the vestigation, in	Cther: 4 Nursin	Death (Check or ing Home 5 F F 28d. Description 28f. Location City or lace, and due to	nly one) Residence ibe how inj on (Street a Town, Sta the cause( me, date a	6 □Other (Specification of the following occurred and Number or Rurate)	al Route Number, tated. the cause(s)
After rus certificate has been structed transported director, page 2 should ilon: To Be Completed	2	examiner?  1 Yes 2 No  27. Manner of Death  1 Matural 5 Pending investigation  3 Suicide 6 Could not be determined  29a. Certifier (Check only one)  1 Certifying Phyone)	28a. Date of Injury (Month, Day)  28e. Place of Injury building, etc.  28i. Place of Injury building, etc.  28i. Place of Injury building, etc.	Year) 28b. Time of Injury  y - At home, farm, st (Specify)  my knowledge, deat examination and/or in	f 28c.  M reet, factory, of h occurred at the vestigation, in	Cther: 4 Nursin	Death (Check or ing Home 5 F F 28d. Description 28f. Location City or lace, and due to	nly one) Residence ibe how inj on (Street a Town, Sta the cause( me, date a	6 Other (Special cury occurred and Number or Rurate)  (s) and manner as s and place, and due to	al Route Number, tated. the cause(s)
After this certificate has been s funeral director, page 2 should tion: To Be Completed	2	examiner? 1	28a. Date of Injury (Month, Day)  28e. Place of Injury building, etc.  28i. Place of Injury building, etc.  28i. Place of Injury building, etc.	Year) 28b. Time of Injury  y - At home, farm, st (Specify)  my knowledge, deat examination and/or in ed.	f 28c. M 28c. h occurred at It vestigation, in 29c. Li	Cther: 4 Nursin	Death (Check or ing Home 5 F F 28d. Description 28f. Location City or lace, and due to	nly one) Residence ibe how inj on (Street a Town, Sta the cause( me, date a	6 Other (Special cury occurred and Number or Rurate)  (s) and manner as s and place, and due to	al Route Number, tated. the cause(s)

DHMH 17 Rev 1/2001

ORIGINAL

		1 - For State Registrar		partment of Health and Nertificate of Death	∕lental Hygier Reg. I		
Physic		1. Decedent's Name (First, Middle, Las	_	Dede	2. Date of Death Month 1 April 22	Pay Year 2005	3; Time of Death 5:00P.M.
/Medi Examii		4a. Facility Name (If not institution, give	,	Dykes 4b. City, Town, or Location of Death		4c. County of Death	J.001 .II.
Funeral	ě	5. Social Security Number 6. Se		Millersville  // If Under 1 Year   If Under 24 Hrs.  Months Days   Hours   Min.	8. Date of Birth (Month, Day, Yea	O Diebol	Arundel
Director		215-40-9459	□M 2 1 4 Yrs.	World S Days Flours Will.			vland
and w		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or I	Location			0d. Inside City Limits
Mary:	tor	Maryland Anne A					1 □ Yes 2 ☑ No
72 hours after death with the Maryland natural', or itams 23e or 28e-f show dital Examinat must be modified at	Director	10e. Street and Number	- I abatem	10f. Zip Code	10g. (	Citizen of What Coun	try?
23a	20	234 Old Magothy I		21122		U.S.A.	
ita hyylene. id other than "natural", or itams 23a or 28a-1 show evant, the Medical Examinar must be notified at	by Funeral	11. Marital Status  1 □ Never Married 2 ☑ Married  3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ ♣ ¶ o If Yes, Give Year or Dates:	. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☐ ₩6 Specify:	ecify Yes or No- Rican, etc.)	14. Race - America Black, White, e Specify:	etc.
atura Ical E	ted	15. Decedent's Ed	ucation 16a, Dec	edent's Usual Occupation	. 16b.	Kind of Business/Ind	nite Hustry
Med "n	Completed	(Specify only highest grad Elementary/Secondary (0-12)	College (1-4or 5+)	re kind of work done during most of work DO NOT use retired)	ain <b>g</b>		
other than '		12 17. Father's Name (First, Middle, Last)	N/A Open	rator & Inspector		atema	
arked of	o Be		M O 11 · 1		e (First, Middle, Maid		
is marked c raumatic ev	10	Thomas  19a. Informant's Name/Relationship (7)	McGoldric Type, Print) McGoldric	Gertrue  Ging Address (Street and Number or Rui	al Route Number, City		
Department of realin and Mer Important: If Itam 27 is marke any injury or other traumatic once.		Philip David Dyke  20a. Method of Disposition  1 Burial 2 Cremation 3 Characteristics  4 Donation 5 Other (Specify  21. Signature of Funeral Service License	Removal from State 20b. Place of Discometery, cr	oosition (Name of ematory or other place)  terans Cemetery 4/2  22. Name and Address of Facility  McGully-Polyniak I	26/05 <u>C</u> :	rownsville	, Marylan
	_	23a Peni Enter the disease or comp	olications that caused the death. Do not e	McCully-Polyniak I 3204 Mountain Road	Pasadena	"MaryTand	21122 Approximate
ysician Medical		shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	one cause on each line.	OF BRIAIN	or respiratory arrest,		Interval Between Onset and Death
physician and is the burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. — Due to (or as a consequence of).  C. — Due to (or as a consequence of):  d. —				
hed by the attending property of detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ♠ No 9 □ Unknown		□Ectopic pregnancy □ Other (specify)		23d. Date of deliver Month	ry Day Year
0.00	by	Part II. Other significant conditions co	ontributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacci	use contribute to the	
ate has been si page 2 should	Completed				24a. Was an autopsy performed?	prior to com death?	ssy findings available apletion of cause of
e ili	Be C	25. Was case referred to medical examiner?		26. Place of Deat	h Check on one		
this al dii	To	1 Yes 2 No	Hospital:		me 5 Residence		)
After	tion	27. Manner of Death  1. Natural 5 Pending 2 Accident investigation	28a. Date of Injury 28b. Time (Month, Day Year) Injury		28d. Describe how in	jury occurred	
1 P	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm, s building, etc. (Specify)		28f. Location (Street City or Town, Sta		Route Number,
within 24 hours an To the Funaral Di completely filled in	edicai C	29a. Certifier Certifying Phyone 2 Medicel Exem	vicien: To the best of my knowledge, dea iner: On the basis of examination and/or and manner stated.	ath occurred at the time, date and place, investigation, in my opinion, death occur	and due to the cause red at the time, date a	(s) and manner as sta nd place, and due to	ated. the cause(s)
withir To th comp	Me	29b. Signature and title of certifier	\ 0.0	29c. License number	29d. [	Date signed (Month, E	Day, Year)
2		1 /or Cca	Villa	03/136	Af	PRIL 25	2005
4		30. Name and address of person who c	completed cause of death (Item 23a) (Type	e, Print)	11-		
	10	31. Date filed (Month Dav. Year)	completed cause of death (Item 23a) (Type CACE W) 9 005	perente ro	DACTIME	re mi)	21236
St Regist	ate rar	31. Date filed (Month Day, Year) APR 2 8 200	5 Brown It Son	all s			

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year Month **Physician** 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death HUnder 24 Hrs. Examiner Hane tartoid If Under 1 Year 5. Social Security Number 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday, 6. Sex **Funeral** Days Year) Months 1 M 2 1 145-20-931 MARYL Yrs AND Director Usual Residence of Deceden death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a, State 27 is marked othar than "natural", or Itame 23a or 28a-f shov traumatic event, the Medical Exame art must be notified at 28a-f ehow 1 ☐ Yes 2 ☐ No Funeral Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 2458 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 2 should be filad within 72 hours after on and Mental Hygiene. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 2 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: WHITE Specify \$ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 6 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be Department of Health and Menta Important: If Itam 27 is marked any injury or other traumatic evants. SAMES THOMAS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BRANCH CIR. NORTH EAST 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State ANATOMY GIFTS KEG \*4 Donation 5 Other (Specify)

21. Signat e Fund Service icensee 22. Name and Address of Facility
Daugherty Family Funeral Home And Cremation Center, P.A. 2601 Mountain Road - Pasadena, MD. 21122 23 Part. Enter the disease, or complications that caused the leath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Metastatic 10 days culon cancer /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Officers or in jury that initiated events Due to (or as a consequence of): Examine igned by the attending physician and be datached for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Box 68760. Completed by Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetel death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 □Ectopic pregnancy Day Month Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☑ No Division of Vital Records, P.O. 9□ Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ **(**o page 2 should certificate has baan 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No ⊭med? 2**∠1**Ne 1 Yes the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 5 Residence 6 Other (Specify) Hospital: 2 No 1 🗌 Yes Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27 Manner of Death 28b. Time of 28c. Injury at Work? After t Hospital or Attanding 1 Natural 5 Pending after death. Diractor: Af 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after de To tha Funeral Diracto completely filled in by th 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Nedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 4/22/05 000048050 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) #400 Aberdeen mo 2100/ 10 15 South Parker Street m Shukla, Prashant 31. Date filed (Month, Day, Year) 32 Registrar's Signature State 2005 Registrar

) Ruide (Inixa

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day Year Barbara Francis Davis APRIL 2005 26 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** HEALTH CARE SAINT AGNES NA POALTMORE If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral**  Birthplace (State or Foreign Country) Days Hours 1 🗆 M 2🗶 F Director <u>066-34-5460</u> 3-23-43 62 N.Y Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show treumetic evant, the Medical Examinar must be notified at Md. 1 Yes 2 No Director NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 5612 St. Mary's St. 21228 USA or items 23a death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2√ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. Int: If itam 27 Is marked other then "natural", or itel 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: ծ Specify: Black 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Data Processing Bloomingdale 12th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Robert Richards Dorothy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Dep rtment of Health a Important: If Itam 27 Is any injury or other tree once. Bobby Davis Husband 5612 St. Mary's Street, Baltimore, Md. 21228 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State `4 Donation 5 Dother (Specify) Pinelawn Cemetery 5-4-05 Pinelawn, N.Y. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Baltimore, Md. 21202 March F.H. East 1101 E. North Ave. warre 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician LEFT SIDE ISCHEMIC 5 DA 45 disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** HYPERTENSION Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine the death certificate be executed Due to (or as a consequence of): burial-t 68760 phy sician Physician/Medical as the IF FEMALE esn 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? ģ Month Day Year 4☐Pregnant at time of death 5 Other (specify) o. the ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? 1 Yes 2/2 No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 Z No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After Medical Certification; the Hospital or Attanding Injury 5 Pending 1 Natural death. 1 ☐ Yes 2 ☐ No investigation 2 Accident Diractor: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗍 Homicide Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) within 24 tha 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0 P17608 Deos 30. Name and iddress of person who completed cause of death (Item 23a) (Type, Print) Dr JACKSON 900 CATON AVENUL BALTMORE 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

			1 - For Stete Registrar	State of Mar		artment of H rtificate of L			giene 📗 🗍 Reg. No.	5	4383
	Physici /Medic		Decedent's Name (First, Middle, Las     Anthony	(1)	Dougl	as		2. Date of Dea Month APRIL	Day	Yeer	Time of Death
	Examin	~ "	4a. Facility Name (If not institution, give 229 NORTH SPRING C	street and number)			Location of Death	•	4c. County NA		
	. Funeral Director		5. Social Security Number 6. Social Security Number 1.		In yrs. last birthday) 55 Yrs.	BALTIMORE If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Day 5-1-4	h y, Year)	9. Birthplace Country)	(State or Foreign
	land ow		Usual Residence of Decedent  10a. State 10b. County	1	0c. City, Town or Lo	ocation				10d. i	Inside City Limits
	death with the Maryland ms 23a or 28a-f show rmat be notified at	Director	Md. NA		Bal	timore					Y☐Yes 2☐No
	with th		10e. Street and Number	Q1		10f. Zip Code	221		10g. Citizen of V	,	
	death	Funeral	229 North Spring 11. Marital Status	12. Was Decedent Ev Armed Forces?	er in U.S. 13.	212 Was Decedent of His If Yes, specify Cubar		ecify Yes or No-		ISA e - American Ir	ndian,
2-0020	ours after ral', or Ite Exertine	þ	1 X Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	1	1 ☐ Yes 21 No	Specify:	Hican, etc.)		k, White, etc. Black	
1-017	be filed within 72 hours after death with the Marylar Ital Hygiene. d other than "natural", or Items 23e or 28e-f show event, Ita Medical Exercinal must be notified at	Completed	15. Decedent's Ed (Specify only highest gra	de completed) College (1-4or 5+)	(Give life.	dent's Usual Occupa kind of work done d DO NOT use retired)	urina most of work	ing	16b. Kind of Bu	School	ols
7	e filed val Hygie other t	a	12th grade  17. Father's Name (First, Middle, Last)	3 yrs	Te	acher	18. Mother's Name	e (First, Middle,			y Public
угапа	2 should be and Mental is marked o	To B	Anderson		Douglas		Mildre	đ	Bro	wn	
Mar	12 sho h and 7 is ma trauma		19a. Informant's Name/Relationship (7	,, ,		ng Address (Street a					fe)
<u>6</u>	f Healt Hem 2 other		Alvin Douglas  20a. Method of Disposition	Brother	290 / 20b. Place of Dispo cemetery, crer	Federal	Street, I	Baltimor Date	ce, Md.	21213 City or Town,	State
Sairimor	Page: nent o ant: If ury or		ty□ Burial 2 □ Cremation 3 □ '4 □ Donation 5 □ Other (Specify	Removal from State	King Mem		″ 4 <b>–</b> 28-	-05	Randall	stown,	Md.
Dail	permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 is marked any injury or other traumatic e once.		21. Signature of Funeral Service Licen	soo Wan	- 1	2. Name and Addres		Balti 1101 F	imore, M E. North	d. 212 Ave.	202
	S. H		23a. Part1. Enter the disease, or comp shock, or heart failure. List only	olications that caused the cause on each line.	e death. Do not ent	er the mode of dying	, such as cardiac o	or respiratory ar	rest,	Inte	proximate erval Between set and Death
	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)		consequence of):	CARDIOUS	SCULAK	DISE	ASE		
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a c	consequence of):						
	ecuted and I-transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	C. Due to (or as a r	consequence of):						
<b>68/6U</b> ,	ificate be executed g physician and as the burial-transit	edical E		d	, on so quon ou on , .						
	± 0 €		IF FEMALE:	00-16							
C. BOX	w requires that the death certif been signed by the attending should be detached for use as	hysician/M	23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown	23c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at tir 9 □ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date Mor	e of delivery oth Day	Year
ds, F.	requires that the een signed by th nould be detache	by P	Part II. Other significant conditions on	entributing to death but	not resulting in the u	nderlying cause give	n in Part I.		obacco use contr		
Hecord	e la has je 2	ompleted						24a. Was a autop perfor	sy p med? d	rior to complet eath?	indings available tion of cause of
VItal	ysician; Th is certificate director, pag	BeC	25. Was case referred to medical examiner?				26. Place of Death	1 ☐ Yes ∩ (Check only or		☐Yes 2☐	No
>   	hys this al di	2	1 XYes 2 No 27. Manner of Death	Hospital: 1 ☐ Inpatient 28a. Date of Injury	2 ER/Outpatien		4   Indising no		ence XXOthe		SCENE
	nding Ph ath. r: After thi e funeral	ation	1 Natural 5 Pending 2 Accident investigation	(Month, Day Y	(ear) Injury	Work	? ′es 2 □ No	200. Describe ii	low injury occurre	<b>3</b> 0	
DIVISION	al or Attending P s after death. il Director: After i id in by the funera	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc.	- At home, farm, str (Specify)	eet, factory, office		28f. Location (S City or Tow	itreet and Numbern, State)	er or Rural Rou	ite Number,
	To the Hospital or Atte within 24 hours after de To the Funeral Direct completely filled in by th	edical (	29a. Certifier (Check only one)	ysician: To the best of einer: On the basis of einer: and manner state	xamination and/or in	n occurred at the time vestigation, in my op	e, date and place, a inion, death occurr	and due to the ded at the time, o	cause(s) and mar date and place, a	nner as stated. nd due to the	cause(s)
	To t withi To tl	W	29b. Signature and title of certifier			29c. License OCME	number	1	29d. Date signed APRIL 2		*
_	H		30. Name and address of person who a	0.1.00	th (Item 23a) (Type,		enn Stre	et Balı	timore,	Maryla	nd 21201
ĮK Ž	Sta Registr		31. Date filed (Month, Day, Year)  APR 2 8 20	32 Registrar's	s Signature	المك					

Completed by Funeral Director	Usual Residence of Decedent  10a. State  10b. County  Maryland Anne A  10e. Street and Number  24 Hill Tpo La  11. Marital Status  1 Never Mamed 2 Married  3 XWidowed 4 Divorced  15. Decedent's Edu	ane 7. Age (In yrs. last I) 10c. City, To rundel Anna	4b. City, Town, or Location of Dea  Annabolis  birthday) If Under 1 Year If Under 24 Hrs Months Days Hours Min  own or Location  polis  10f. Zip Code	th 8. Date of Birth	ear) Cou	hplace (State or Foreign
by Funeral Director	24 Hill Top L  5. Social Security Number  6. Security Number  10. State  10b. County  Maryland Anne A  10e. Street and Number  24 Hill Top La  11. Marital Status  1 Never Mamed 2 Married  3 XWidowed 4 Divorced	ane 7. Age (In yrs. last I) 10c. City, To rundel Anna	Annapolis  If Under 1 Year If Under 24 Hrs  Months Days Hours Min  Down or Location	8. Date of Birth (Month, Day, Ye	ANNE A	hplace (State or Foreign
by Funeral	5. Social Security Number 6. Second 10 10 10 10 10 10 10 10 10 10 10 10 10	rundel Anna	birthday) If Under 1 Year If Under 24 Hrs  Yrs. Months Days Hours Min  own or Location	. (Month, Day, Ye	ear) Cou	untry)
by Funeral	Usual Residence of Decedent  10a. State  10b. County  Maryland Anne A  10e. Street and Number  24 Hill Tpo La  11. Marital Status  1 Never Married  3 XWidowed 4 Divorced	rundel Anna	Yrs. Months Days Hours Min	. (Month, Day, Ye	ear) Cou	untry)
by Funeral	10a. State 10b. County  Maryland Anne A  10e. Street and Number  24 Hill Too La  11. Marital Status  1 Never Married 2 Married  3 AWidowed 4 Divorced	rundel Anna	polis		1314 118	Lyland
by Funeral	Maryland Anne A  10e. Street and Number  24 Hill Tpo La  11. Marital Status  1 Never Mamed 2 Married  3 XWidowed 4 Divorced	rundel Anna	polis			
by Funeral	10e. Street and Number  24 Hill Tpo La  11. Marital Status  1 Never Mamied 2 Married  3 XWidowed 4 Divorced	ne				10d. Inside City Limits 1 ☐ Ves 2 ☐ No
by Funeral	24 Hill Tpo La  11. Marital Status  1 Never Mamed 2 Married  3 XWidowed 4 Divorced		1 Tot. Zip Code	1.0		
þ	11. Marital Status  1 Never Mamed 2 Married  3 XWidowed 4 Divorced  15. Decedent's Edu			10g.	Citizen of What Co	•
þ	1 Never Married 2 Married 3 XWidowed 4 Divorced 15. Decedent's Edu	<ol><li>Was Decedent Ever in U.S.</li></ol>	21403  13. Was Decedent of Hispanic Origin? (	Specify Yes or No-	14. Race - Amer	
þ	15. Decedent's Edu	Armed Forces? 1 ☐Yes 2Ñ No	If Yes, specify Cuban, Mexican, Pue	rto Rican, etc.)	Black, White	
Completed	15. Decedent's Edu	If Yes, Give Year or Dates:	1 ☐ Yes 2 ☑ Mo Specify:		Specify: Bl	iack
Compl	(Specify only highest grad	cation 16 le completed)	Sa. Decedent's Usual Occupation (Give kind of work done during most of wo	orking 16b	. Kind of Business/l	Industry
Ö	Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO NOT use retired)			
	12th 17. Father's Name (First, Middle, Last)	6 yrs.	Homemaker 18 Mother's No.	me (First, Middle, Maid	Vone	
Be				,	sen Sumame)	
ဥ	Simon Gholso  19a. Informant's Name/Relationship (T)		9b. Mailing Address (Street and Number or F	E_Edwards	itv or Town. State. Z	Zip Code)
	Deborah Cottrel		24 Hill Top La.		200	s cos
	20a. Method of Disposition	20b. Place	of Disposition (Name of stery, crematory or other place)		. Location - City or	
	1X Burial 2 ☐ Cremation 3 ☐ F  `4 ☐ Donation 5 ☐ Other (Specify)		date Memorial	6/05 Ar	erano escuaro escreto de caso	
	21. Signature of Funeral Service Licens		22. Name and Address of Facility		nnapolis	
	Lavy D. A	eese 10048	3 Wm. Reese & Son 821 West St. An	s Mortuar	Md. 214	0.1
	23a. Part1. Enter the disease, or composhock, or heart failure. List only of	lications that caused the death. D	to not enter the mode of dying, such as cardia	ic or respiratory arrest,		Approximate Interval Between
	Immediate Cause (Final disease or condition	Mctagtati	c bladder Ca	ncer		Onset and Death
	resulting in death)	a				×/ /
Ļ			A.			year
nlne	cause. Enter Underlying	Due to (or as a consequent	Se OI).			
xar	that initiated events resulting in death) Last	c	ce of):			
cal		d				
70						
an/N	23b. Was decedent pregnant		ath 3 Ectopic pregnancy		23d. Date of deli	*
SICI	1 ☐ Yes 2 ☑ No				Month	Day Year
Phy		atributing to death but not reculting	e in the underlying sever gives in Best I	22a Did tabaa	on una annimita ta	the sauce of death?
by	Part II. Other significant conditions co	nttibuting to death but not resulting	g in the diluenying cause given in Patti.			obably 4 Unknown
etec				-		
шр				autopsy	prior to d	itopsy findings available completion of cause of
O	OF Man ones referred to medical			1 ☐ Yes 2 ☑	No 1□Yes	2 No
8	examiner? /	Hospital:	Othor	/	- 6	3.00
	27. Manpfer of Death		Outpatient 30 DOA 40 Nothing			siry)
atlor	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury Work?  M 1 Tes 2 No			
Ö	dataminad	28e. Place of Injury - At home	, farm, street, factory, office	28f. Location (Stree	t and Number or Ru	ıral Route Number.
Ξ	/	Sullowing, oto. (Opoolity)		0.17 0.17 0.1111, 0	1010)	
Certif	29a. Certifier 1 Certifying Phy (Check only 2 Medical Exam	vsician: To the best of my knowled iner: On the basis of examination	dge, death occurred at the time, date and place and/or investigation, in my opinion, death occurred.	e, and due to the caus	e(s) and manner as	stated.
ical Certification;		and manner stated.			,	
	one)		20n Liannan numbar	00-1	Data signed (Mare)	h Day Vaasi
Medical Certifi	29b. Signature and title of certifier	C.111 -	29c. License number	29d.	Date signed (Month	h. Day, Year)
	one)	Celle mis	7)4141	29d. A	Date signed (Month	h. Day, Year)
To Be Completed by Physician/Med	cellineaudii, to be completed by infairing medical	23a. Part1. Enter the Issase, or compshock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (bisease) or unjury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	23a. Part1. Enter the Isease, or comilications that caused the death. Discock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease) in injury that initiated events resulting in death) Last  IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1	23a. Part1. Enter the issase, or comflications that caused the death. Do not enter the mode of dying, such as cardia shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Underlying Cause) unjury that infilated events resulting in death) Last    Due to (or as a consequence of):	23a. Part I. Enter the Assase, or comflications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underfying that imidated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  C.  Due to (or as a consequence of):  Due to (or as	23a. Part I. Enter the Assase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart fatility. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Unserded or Impur) that inditated events resulting in death)  Let a consequence of):  Due to (or as a consequence of):  Due t

		1 - For State Registrar		State of	Marylan		rtment of I tificate of		Mental H	/giene Reg. No.	2005	1438
		1. Decedent's Name	(First, Middle, L	ast)					2. Date of D	eath		3. Time of Death
Physic /Med		Debo:	rah A.	DiSeta					Month	2 2 Day	2005	11:44 6
Exam		4a. Facility Name (If	not institution, g	ive street and numb	oer)		4b. City, Town, o	or Location of De	ath	4c.	County of Death	7
		FrANKE	LIN SO	uxce.	HOSPI	1AL	Ki	seda	le	1	3A1+	imore
Funera		5. Social Security Nu	-	Sex 7. 1 ☐ M 2 <b>X</b> F	Age (In yrs. I		If Under 1 Year Months Days			av. Year)	Con	place (State or Foreigntry)
Directo	r	218-48-		10 M 28 F	55	Yrs.			m. (Month, L Marc	h31,	1950 N	lass.
land land		10a. State	10b. County		10c. City	, Town or Loc	ation					10d. Inside City Limit
Mary 18h	ō	MD	Balti	more		Bo	wleve (	Quarter	· C			1 □ Yes <b>©</b> □ N
the	Director	10e. Street and Num					10f. Zip Code	guar cer		10g. Citiz	zen of What Cou	ntry?
T with	<u>=</u>	414 Ca:	rroll	Island F	Road			220		US		,
deatl	Funerai	11. Marital Status		12. Was Deced	ent Ever in U.	S. 13. W			(Specify Yes or Nerto Rican, etc.)		4. Race - Ameri	can Indian,
21215-0036 within 72 hours atter death with the Maryland giene.	by Fu	1 Never Marrie		Armed Forc 1  Yes 2 If Yes, Give Year or Date	<b>X</b> No		Yes, specify Cub □ Yes 2🏿 No		erto Rican, etc.)	1	Black, White, SpecifyWhi	
2 hou	ted		15. Decedent's	Education	1	16a. Decede	ent's Usual Occur	pation		16b Kir	nd of Business/Ir	dustry
215 7 ala 7 ala 6 ala 8 a ala 8 a ala 8 a al 8 ala 8 br>a 8 a a 8 a a 8 a a a 8 a a 8 a a 8 a	Completed	(Special Elementary/Second		rade completed) College (1-4	0.5.\	(Give k life. D	ind of work done O NOT use retire	during most of w	vorking		imus	loustry
27.	E O	12th	July (0-12)	College (1-4	01 3+)	Pro	of Read	der		1	nmunica	tion
and 21215-0 d be filed within 72 ho ental Hygiene. red other than "nature	Be	17. Father's Name (F	First, Middle, Las	st)				18. Mother's N	ame (First, Middl	e, Maiden	Sumame)	
	P	Harold	C. Spa	aulding				HAze	l Bank	5		
Maryla Maryla d 2 should th and Mer 7 is marke		19a. Informant's Nar							Rural Route Num			
L La Ca				iSeta /h				llIslan	d Road	Balt	timore	MD
Or oth or oth		20a. Method of Dispo		☐Removal from St.		ace of Dispos metery, crem	ition (Name of atory or other pla	ce)	Date	20c. Loc	cation - City or T	own, State
altimori mit. Pages partment of h portant: If like y injury or or		° 4 □ Donation				viewC:	remator	ry 🛂/.	26/05	Balt	timore	MD
Baltimo permit. Page Department of important: If any injury or once.		21. Signature of Fun	erat Service Lic	ensee	00	22.	Name and Addre	ess of Facility C	onnelly	Fune	ralHom	eofEssex
		23a Part 1 Enter th	edicasea or a	cations that cau	ull				Baltin		MD 212	
The state of the s		23a. Part1. Enter the shock, or heart		one cause on eac	the deal.	not ente	r the mode of dyli	ng, such as cardi	ac or respiratory	arrest,		Approximate Interval Between Onset and Death
Physician /Medical		Immediate Cause (F disease or condition resulting in death)	inai	_ a	tsv4	stol	2					Onset and Death
Examiner		, and an account	-	Due to (or	as a consequ	ence of):	١٨	0 - 1.	100	-		
	20	if any, leading to improduce. Enter Under	ditions	b. Due to (or	a consequ	ance of:	rel 11	facts	.QN			
nsit	Examiner	cause. Enter Under Cause (Disease or in that initiated events	lying njury	10	~ hor	N 37	C10 1	MCV RS	Untra	W		
58760, circate be executed physician and sthe burial-transit	xai	that initiated events resulting in death) La	ast	c. Due to (or	as a consequ	ence of):	٠.,١		$\theta \sim 1$	1		
8760, cate be exc	dicail									1.0		
68° tifficat g phy as the	0			J								
OX ondin use	Physician/M	IF FEMALE: 23b. Was decedent	pregnant	23c. If yes, outco						2	3d. Date of delive	erv
Geatle death	icia	in the past 12 n		4□Pregnar	h 2 ∏ Fetal nt at time of de		ctopic pregnance Other (specify)	у			Month	Day Year
P.O. I hat the de od by the a	hys	9 🗆 Unknown		9□ Unknow	m							
IS, Fires that igned be det	by P	Part II. Other signific	cant conditions	contributing to deal	th but not resu	lting in the und	derlying cause giv	ven in Part I.	23e. Did	tobacco us	se contribute to t	he cause of death?
Cord: w require been sig	ed h	- KATAN	ic 10	val to	~1/W	re.			. 10	Yes 2	Mo 3 ☐ Prot	abiy 4 Unknown
aw re	piet	Dinhe	tes N	nell, tu	5	TUNE	2		24a. Wa		24b. Were auto	psy findings available
Division of Vital Records, for Attending Physician: The law requires the elter death.  Director: After this certificate has been signed in by the tuneral director, page 2 should be d	Completed	11200	10-set no	000 H	21200	toms	100			ormed?	prior to co death?	mpletion of cause of
Vital F ician: Th certificate	0	25. Was case referre	ed to medical	Vex 11	4121	1 1/1/3		26 Place of Di	1 ☐ Yes eath (Check only	2 100	1 ☐ Yes	2110
f Vi yeici	To B	examiner?	lo	Hospital:	atient 2 2	R/Outpatient	3□ DOA Oth		Home 5 ☐ Res		□Other (Specif	iv)
On Of ding Ph h. After thi tuneral		27. Manner of Death		28a. Date of		28b. Time of Injury	28c. Injur Wor	ry at	28d. Describe			77
ision Attendin death. ctor: Af	atio	1 Natural 2 Accident	5 Pending investigation		Day roar,	пцигу		Yes 2 □No				
IVIS ratte er de recto	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could not determine	d 286. Place of	Injury - At hor , etc. (Specify	me, farm, stree	et, factory, office		28f. Location	(Street and wn, State)	Number or Rura	d Route Number,
Ditaion rs ett	Cer			bulldarg	, oto. (opeony,	,			City of To	wii, State)		
Divisio  To the Hospital or Attendit within 24 hours after death. To the Funeral Director: A completely tilled in by the tu	Medicai	29a. Certifier (Check only one)   29a. Certifier (Check only one)   29a. Certifier (Check only one)   20a. Certifier (Check one)   20a. Certifier (Check one)   20a. Certifier (Check one)   20a. Certifier (Check one)   20a. Certifier (Check one)								cause(s) a	and manner as s place, and due to	tated. o the cause(s)
ithin o th	Me	29b. Signature and to	itle of certifier	and mainte	Statoo.		29c. Licens	se number		29d, Date	signed (Month,	Dav. Year)
F S F O	į	Dec	201	2 1	as		Ds	38882	,	4,	21-15	<b>~</b>
<b>O</b>		30. Name and addre	ss of person who	Completed cause	of death (Itom	23a) /Tues P				_ / /	1310	<i>-</i>
4		DR. A		B 900	o Fra	KI'A	59 U.A	Me Dr	. BaL	rb. /	45 21	237
S	tate	31. Date filed (Month		32, Reg	istrar's Signat	1L6	700.		,		- 0.1	
Regis		AF	PR 282	005	istrar's Signat	1	AP 10					
DHMH 17 Rev 1/	2001			Julie .	NO SO	1						

			State of Maryland / Department of Health and  1- For State Registrar  Certificate of Death	Mental Hy	giene n n 5	14386
			1. Decedent's Name (First, Middle, Last)	2. Date of Dea	Reg. No.	3. Time of Death
	Physici	an	Paul Robert Dougherty	Month April	Day Year	
	/Medio Examin		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Deal	<del></del>	26, 2005 4c. County of Dea	5:45 A M
	LXumm	-	Greater Baltimore Medical Center Towson		Baltimore	
	Funeral Director		5. Social Security Number 217-20-2584 6. Sex 12 F 7. Age (In yrs. last birthday) 15 P 79 Prs. 15 P 15 P 15 P 15 P 15 P 15 P 15 P 15	(Month, Day	h 9. Bir	thplace (State or Foreign ountry) aryland
	and w		Usual Residence of Decedent         10a. State         10b. County         10c. City, Town or Location			10d. Inside City Limits
	be filed within 72 hours after death with the Maryland tal Hygiene. od other than "natural", or tlems 23a or 28a-f show evant, the Medical Exameration into the invitible at	Director	Md. Baltimore Timonium  10e. Street and Number 10f. Zip Code		10g. Citizen of What Co	1 □Yes 2 🔀 No
	3a or		412 Rockfleet Road Condo #102 21093		USA	
	deat	Funeral	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer	Specify Yes or No-		
36	within 72 hours after ene. than "natural", or Ite	by Fu	1 Never Married 2√Married 1XOVes 2 No If Yes, Give 1,11,1 T 1 Yes 2√DMNo Specify:	to Hican, etc.)	0	
21215-0036	hour tural'	ed b	3 Wildowed 4 Divorced Year or Dates: WWII  15. Decedent's Education 16a. Decedent's Usual Occupation		, , , , , , , , , , , , , , , , , , ,	hite
<u>-</u>	n "na	Completed	(Specify only highest grade completed) (Give kind of work done during most of wo	nking	16b. Kind of Business	industry
72 22	d with	mo	Elementary/Secondary (0-12)  College (1-4or 5+) 4  Senior Vice President		Farm Credi	t Banks
	al Hy a othe	Be	17. Father's Name (First, Middle, Last)  18. Mother's Name	me (First, Middle,	Maiden Surname)	
<u> </u>	ould to Ment arked	입		Carrie		
ty, f	s 1 and 2 should be filed within Health and Mental Hygiene. Item 27 is marked other than "other traumatic event, If a Me.		19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Ri			
	2 = 2 =	,	Mrs. Joan D. Dougherty/Wife 412 Rockfleet Rd. Cond	00 #102 Date	20c. Location - City or	
ingher Baltimore,	ages ont of it: If it y or o		20a. Method of Disposition  1 \( \sumething \) Burial 2 \( \sumething \) Cremation 3 \( \sumething \) Removal from State  1 \( \sumething \) Donation 5 \( \sumething \) Other (Specify)  20b. Place of Disposition (Name of cometery, crematory or other place)  1 \( \sumething \) Ulaney Valley Mem. Grd.			
20 =	nit. P artme ortan injur.					
ට <b>ස</b>	Dep imp any				on Funeral aryland 212	
A			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardia shock, or heart failure. List only one cause on each line.			Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition Acute Myocardial Infarction			Onset and Death
	/Medical Examiner		Due to (or as a consequence of):			1424.4.4
	ZAGIIIIICI	-	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):			years
	ted nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events  C.			
ć	be executed sician and burial-transit	Exar	that initiated events c. resulting in death) Last Due to (or as a consequence of):			
760,	w ~ 0	cai	d			
89	tificat ng phy as th	ledi				
Box 687	th car tendir or use	an/h	IF FEMALE: 23b. Was decedent pregnant in the cast 13 meeths?  1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy		23d. Date of del	
120	uires that the death certificate be ex signed by the attending physician d be detached for use as the buria	Physician/Medi	in the past 12 months?  1		Month	Day Year
P. 0.	hat the	Phy	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e Did to	bacco use contribute to	the source of death?
ds,	The law requires that the death certifical ate has been signed by the attending phypage 2 should be detached for use as the	d by	Alcohol abuse / withdrawal			robably 4 Unknown
17.0	w requir been si should	Completed	COPD	24a. Was	24h Were au	itopsy findings available
Be	rician: The lav certificate has rector, page 2	dwc		autop perfor	sy prior to death?	completion of cause of
tal	an: T tificat tor, pa	0	25. Was case referred to medical 26. Place of De	1 ☐ Yes ath (Check only or		22 No
>	ysici lis cer direc	To B	examiner?		ence 6 □Other (Spe	cify)
0	ding Physician: The I h. Affer this certificate he funeral director, page		27. Manner of Death 1 ☑Natural 5 ☐ Pending 28a. Date of Injury (Month, Day Year) 28b. Time of Injury at Work?		ow injury occurred	3,
Sio	tendil leath. tor: A the fu	cati	2 Accident investigation M 1 Yes 2 No			
下名光 Division of Vital Records,	or At after d Direct in by	Certification;	4 Homicide  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (S City or Tow	treet and Number or Run, State)	ral Route Number,
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifics completely filled in by the funeral director, to	Medical Co	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place and manner stated.	e, and due to the curred at the time, c	ause(s) and manner as late and place, and due	stated.
	o the o the omple	Me	29b. Signature and title of certifier 29c. License number		29d. Date signed (Mont	h, Day, Year)
	(		Reun E- Ilional MD D60630		4/26/05	* '
	of	/	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)			
_	( A 0		Renu E. Thomas, 6701 N. Charles St. Suite 3	3853, To	wson, MI	121204
	Sta Registr	•	31. Date filed (Month, Day, Year)  32. Registrar's Signature			

Physician (Medical Examiner  45. Failly Name (If nor institution, give street and number)  46. Clty, Town, or Location of Death  47. Os (If Norm, or Location of Death  47. Os (If Norm, or Location of Death  48. Failly Name (If nor institution, give street and number)  48. Failly Name (If nor institution, give street and number)  48. County of Death  NIA  48. County of Death  NIA  48. County of Death  NIA  48. County of Death  NIA  48. County of Death  NIA  48. County of Death  NIA  10. Sciel Security Number  10. Sciel Security Number  10. Street and Number  10. Street and Number  10. Street and Number  10. Street and Number  10. Street and Number  10. Street and Number  10. Street and Number  10. Street and Number  10. Street and Number  11. Marital Status  11. Marital Status  12. Was Decadent Ever in U.S.  13. Was Decadent Hispanic Origin? (Specify Yes or No-Wind, Medican, Puerto Rican, etc.)  11. Now of Death  11. Now of Death  12. Was Decadent Ever in U.S.  13. Was Decadent Figure (Distan, Medican, Puerto Rican, etc.)  11. Now of Death  12. Was Decadent Ever in U.S.  13. Was Decadent Figure (Distan, Medican, Puerto Rican, etc.)  14. Race American Indian, Specify Cuben, Medican, Puerto Rican, etc.)  15. Decadent's Education  16. Decadent's Cluster of work done during most of working  16. Decadent's Usual Occupation  16. Decadent's Name (First, Middle, Maiden Sumame)  17. Father's Name (First, Middle, Maiden Sumame)  18. Mother's Name (First, Middle, Maiden Sumame)  19. Mailing Address (Street and Number or Puerto Rican, etc.)  19. Mailing Address (Street and Number or Puerto Rican, etc.)  19. Mailing Address (Street and Number or Puerto Rican, etc.)  19. Mailing Address (Street and Number or Puerto Rican, etc.)  19. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  10. Table of Street and Number or Rural Route Number, City or Town, State, Zip Code)  10. Table of Street and Number or Rural Route Number, City or Town, State, Zip Code)  10. Table of Street and Number or Ru		1	For State Registrar	State of Marylan		artment of H			giene Reg. No.	5 1438
\$5.5000 Society Number  \$5.500	/Medica		Anna Mae  ta. Facility Name (If not institution, give	Edwards re street and number)			r Location of Dea	Month 4	24 20x 4c. County of D	S 14.05
The State of December   The			5. Social Security Number 6. 5 215–22–4077	Sex 7. Age (In yrs.	last birthday)	If Under 1 Year	If Under 24 Hrs	. (Month, Da	h y, Year) 9.1	Birthplace (State or Fore
233. Part 1. Einer the disease, or complications that caused the death. Do not enfer the mode of dying, such as cardiac or respiratory arrest,    Mc. 21014	Sa-f show		10a. State 10b. County Md. Harford		y, Town or Lo					10d. Inside City Lin 1 ☐ Yes 2 🔀
ysician Idedical amilior  ysician Idedical Ide	I Examiner must be no House must be no House innered Direct	Dy i diferal Dife	1102 Jade Drive 11. Marital Status 1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give	1	21 Was Decedent of H	lispanic Origin? (S an, Mexican, Puer		U.S.A.  14. Race - A Black, W	merican Indian, hite, etc.
238. Part 1. Einer the disease, or complications that caused the death. Do not enfor the mode of dying, such as cardiac or respiratory arrest.  239. Part 1. Einer the disease, or complications that caused the death. Do not enfor the mode of dying, such as cardiac or respiratory arrest.  230. Part 1. Einer the disease, or complications that caused the death. Do not enfor the mode of dying, such as cardiac or respiratory arrest.  230. Was ease (Final property of the season of the season of the property of the season of the property of the season of the property of the season of the property of the season of the property of the season of the property of the season of the s	tyglene. ther than "natunt, the Medical		(Specify only highest gr. Elementary/Secondary (0-12)	completed) College (1-4or 5+) 5+	(Give	kind of work done DO NOT use retire	during most of wo		educat	·
238. Part 1. Einer the disease, or complications that caused the death. Do not enfor the mode of dying, such as cardiac or respiratory arrest.  239. Part 1. Einer the disease, or complications that caused the death. Do not enfor the mode of dying, such as cardiac or respiratory arrest.  230. Part 1. Einer the disease, or complications that caused the death. Do not enfor the mode of dying, such as cardiac or respiratory arrest.  230. Was ease (Final property of the season of the season of the property of the season of the property of the season of the property of the season of the property of the season of the property of the season of the property of the season of the s	is marked of aumatic ever		Wilmer Kerber  19a. Informant's Name/Relationship	Турө, Print)			Katheri and Number or R	ne Schmi	dt or, City or Town, State	a, Zip Code)
Sician   Colical annihity   Sician   Colical annihity   Sician   Colical annihity   Sician   Colical annihity   Colical annih	int: if item 27		20a. Method of Disposition 1 □8urial 2 □ Cremation 3 □	Removal from State	Place of Disposemetery, cre	osition (Name of matory or other place	ce)	Date	20c. Location - City	
Section   Part   Control   Part   Part   Control   Part   Par	Importa any inju		1000		9	Schimunek	Funeral	Home of	Bel Air, Air, Md.	Inc. 21014
FFEMALE:   23b. Was decedent pregnant in the past 12 months?   1   1   1   1   2   Fetal death   3   Ectopic pregnancy   1   1   1   2   Fetal death   3   Ectopic pregnancy   1   1   2   2   Fetal death   3   Ectopic pregnancy   1   1   2   2   2   2   2   2   2   2	Medical aminer per per per per per per per per per p	ical Examin	Sequentially list conditions, if any, leading to immediate cause. Either Underlying Cause (Disease or injury that initiated events	b. Due to (or as a conseq c.	uence of):	itis				Onset and Death
1   Yes 2   No 3   Probably 4   Unkning to death building to death	attending for use a	1 yalcıdı Vinet	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ⋈ No	1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d	Ideath 3		,			,
autopsy performed performe	e gue	2	Part II. Other significant conditions	contributing to death but not res	ulting in the u	inderlying cause giv	en in Part I.		J.	
1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	icate has be							autop perfo	rmegi? prior death	o completion of cause ?
1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	oath.  7: After this certine funeral directors.	2	examiner 1 Ves No  27. Manner of Death  Shatural 5 Pending investigation investigation	28a. Date of Injury (Month, Day Year)	28b. Time o	f 28c. Injur	er: 4 □ Nursing I y at k?	Home 5 ☐ Resid	dence 6 Other (S	oecify)
15001 9/2016	nours after dineral Direct		4 Homicide determined	building, etc. (Specification)	y) owledge, deal	h occurred at the time	πe, date and plac	City or Tow	vn, State)	as stated
	within 24 r To the Fui completely	Medic	(Check only 2 Medical Exa	miner: On the basis of examina and manner stated.	ition and/or in	29c. Licens	e number	urred at the time,	29d. Date signed (Mo	onth, Day, Year)

DHMH 17 Rev 1/2001

	1	For State Registrer	State of	Marylan	•	artmen rtificat			ind M	lental H	ygien Reg. N	201	)5	14388
Physician /Medical	1	1. Decedent's Name <i>(First, Middle, La</i> Steve Ely	st)							2. Date of D Month APRII	eath D	ay	Year	3. Time of Death
Examiner		ta. Facility Name (If not institution, giv SAINT AGNES HE						Location o	•		4	c. County		
uneral irector		5. Social Security Number 6. S 037-24-5201	ex ☑M 2□F	7. Age (In yrs.	last birthday) Yrs.	If Under Months	1 Year Days	If Under 2 Hours	24 Hrs. Min.	8. Date of B (Month, L 3-29-	inth 1929	r)	9. Birth Ph	place (State or Foreign Tadelphia, P.
fled at		10a. State 10b. County 10b. MD Baltimo	re		y, Town or Lo									10d. Inside City Limits 1 ☐ Yes 2 ☒ No
or items 23a or 28a-1 st That must be notified Fineral Director	al Dile	10e. Street and Number 98 Smithwood Ave				10f. Zip 212			_		10g. C	itizen of \	What Cou	intry?
	2	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	12. Was Deced Armed For 1 Tes If Yes, Give Year or Da	ces? 2⊠No	9	Was Deced If Yes, spec 1  Yes			gin? (Spe , Puerto	ecify Yes or N Rican, etc.)	lo-	Blac	ck, White	ican Indian, , etc. nanian
aumatic event, the Medical Exa	analdino	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)	ducation ide completed) College (1-	4or 5+)	16a. Dece (Give life. Outdo	kind of wo DO NOT u	rk done d se retired	luring most )	of worki	ing		Kind of Bu		ndustry
atic event	מ	17. Father's Name (First, Middle, Last, Pete Ely						18. Mothe Mary		(First, Midd	le, Maide	n Suman	пө)	
n 27 is ma ier trauma		19a. Informant's Name/Relationship ( John Ely/ Grandso			107 M	ain S	Stree		napo.	lis MD		_	State, Zi	p Code)
Important: If item 27 is any injury or other tra once		20a. Method of Disposition  1 □ Burial 2 □ Cremation 3 □ □ □ Donation 5 □ Other (Special Control of the Contro		1210	Place of Dispo cemetery, crei	natory or c	ther plac	θ) Δ		-2005		Location - ltimo		own, State MD
any in	(	21. Signatura o Funeral Service Lice	DO	100	9 2	Name ar Throi	d Addresse Fi	s of Facility Ineral Onds I	Hor	me of L	Lans	downe	e MD 2	21227
sician edical		23a. Part1. Enter the disease, or com- shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. ACUT	ch line.	OCARD						arrest,			Approximate Interval Between Onset and Death
hysician and the burial-transit and the burial-transit and the burial-transit and the burian are	alcal Ex	Soundaily stemplors if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. URC Due to (d	or as a consequence or a consequence o	Usence of):									5-2645
hed for use as	Iysiciaiivine	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No		nth 2 ☐ Feta ant at time of c	al death 3	Ectopic pi Other (sp						23d. Da Mo	te of deliv	rery Day Year
be o	2	Part II. Other significant conditions	contributing to de	ath but not res	sulting in the u	nderlying o	ause giv	en in Part I.				use cont		the cause of death?
certificate has been sector, page 2 should	completed									per 1 ☐ Yes	opsy formed? 2 M		death?	opsy findings available ompletion of cause of
After this	27. Manner of Death  1					8c. Injun Wor	er: 4□ Nui	rsing Ho	me 5□Re	ck on one  ☐ Residence 6 ☐ Other (Specify)  escribe how injury occurred			fy)	
within 24 hours after dear To the Funeral Director: completely filled in by the	Cermin	3 ☐ Suicide 6 ☐ Could not to determined	De One Blees of laive. At home for the		reet, factory	, office			28f. Location (Street and Number or City or Town, State)		er or Rur	al Route Number,		
To the Fune completely file	Medical	(Check only 2 Medice! Exa	nysicien: To the miner: On the ba and mann	sis of examina	owledge, deat ation and/or in	vestigation	, in my o	oinion, deat	place, and due to the cause(s) and mann n occurred at the time, date and place, an			anner as s and due t	stated. to the cause(s)	
To	2	29b. Signature and title of certifier  Mmy Pn+6	<u>CL</u>					s number			29d. Date signed (Month, Day, Year)  APRIL 21 2005			Day, Year)
1		30. Name and address of person who DR-M JACKSON,	POD CA	A LAST	VEALINE	RA	L711	NORE	, n	1.7 -2				
State Registra	-	31. Date filed (Month, Day, Year)	005 33/A	gistrar's Signa	to A	الماد								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** APRIL 2005 **EPSTEIN** 1:20 P M MILTON /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** MONTGOMERY CASEY HOUSE ROCKVILLE If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. 01/08/1920 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex **Funeral** Months 1 M 2□ F 85 Yrs Director 067-12-9198 MI Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Director MD MONTGOMERY SILVER SPRING 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 14510 HOMECREST ROAD APT. # 4015 20906 U.S.A. Funeral Pages 1 and 2 should be filed within 72 hours efter death nent of Heelth and Mental Hyglene.
ant: If Item 27 is marked other then "naturel", or Items 23, any or other treumstic event, the Medical Exercities for item. 12. Was Decedent Ever in U.S. Armed Forces? 1 XX Yes 2 □ NoA RMY If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White atc WHTTE 1 Never Married 2 Married 1 ☐ Yes 2 Å No Specify: Specify. Ď 3 ☐ Widowed 4 ☒ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) **FOREMAN** LITHOGRAPH 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be JAKE **EPSTEIN** ပ JENNIE PRAGER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) rtent: If Item 27 is ALAN EPSTEIN / SON 10359 CURRY COMB CT. COLUMBIA, MD 21044 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State MARYLAND VETERANS 04/27/2005 OWINGS MILLS, MD 4 ☐ Donation 5 ☐ Other (Specify) permit.
Departn
Importe
any inju 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licensee 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ADVANCED NON-SMALL CELL LUNG CANCER /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) by Physician/Medical Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) IF FEMALE: for use 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 X Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s has autopsy 2 No 1 Yes Hospital or Attending Physicien: director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 DOther (Specify) HOSPICE 1 ☐ Yes 2 🗶 No Certification: To this 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 5 Pending investigation 1 X Natural 2 Accident 1 ☐ Yes 2 ☐ No death. after deatl Director: 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical within 24 hc To the Fun completely (Check only one) and manner stated. 29b. Signature and 29d. Date signed (Month, Day, Year) M name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 1/2001

State

Baltimore, Maryland 21215-0036

Box 68760,

P.O.

Records,

Division of Vital

APR 2.8 2005

31. Date filed (Month, Day, Year)

JET 05-02831 Frank Fuchs

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

ık	Fuchs		1- StateUnpend Item 2	State of Ma 23a&27 per	arylan <b>m</b> e G	d / Depa 843 <i>උ</i> [-	artme 1570 rtifica	nt of H	lealth a Death	ınd Me	ental Hyg	jiene	2005		1.200
	Physici	an	1. Decedent's Name (First, Middle, La	•							2. Date of Dea	ith	0 0		Time of Death
	/Medic		Frank Fu								April		2005	C	9:20 AM
4	Examin	er	4a. Facility Name (If not institution, give				_		Location of	f Death		4c. County of Death			
1	Funeral		1352 B Cooptown F 5. Social Security Number 6.5	ex 7. Age	e (In yrs. I	last birthday)	If Und	est er 1 Year	If Under 2		. Date of Birth	Harford  9. Birthplace (State or Foreign			
	Director		220-84-8811	X M 2 □ F	7.	3 Yrs.	Month:	Days	Hours	Min.	Jan. 5.	19		Country) erma	-
	pue M		Usual Residence of Decedent  10a. State 10b. County		10c Cin	y, Town or Lo	cation								
	the Marylar 28a-f show	5		a				1						]	nside City Limits 1 ☐ Yes 2 ☑ No
	28a-	rect	Maryland Harfor  10e. Street and Number	<u>u</u>		Forest		L ip Code				10a. Citi	zen of What		X
	h with	i D	1352 B Cooptown	Road				210	)50				anada		
	within 72 hours after death with the Maryland ane. than "natural, or itams 23a or 28a-f show than "natural, or itams 21a or 28a-f show he Mudical Externitual to ast be notified at	Funeral Director	11. Marital Status	12. Was Decedent I Armed Forces?	Ever in U.	S. 13.	Was Dec			gin? (Speci	fy Yes or No- can, etc.)		14. Race - A		ndian,
36	or ft	y Fu	1 ☐ Never Married 2 ☐ Married	1 Tes 2V	10			2€ No	Specify:	, ruento m	can, etc.,		Black, W		
21215-0036	hours tural'	ed by	3 ☐ Widowed 4 反 Divorced	Year or Dates:											
15	in 72 n *na	Completed	15. Decedent's E (Specify only highest gr	ide completed)		16a. Dece (Give life.	kind of w DO NOT	vork done d use retired	ation during most ()	of working	,	16b. Ki	nd of Busine	ss/Industr	У
212	d with giene or tha	mo	Elementary/Secondary (0-12)	College (1-4or 5	+)			river				T	ranspo	rtat	ion
	al Hy al Hy d other	Bec	17. Father's Name (First, Middle, Last	)					18. Mother	r's Name (	First, Middle,	Maiden	Sumame)		
yla	ould to Ment Markac	٥	Frank Fuchs								th UK				
Maryland	ges 1 and 2 should be filed within 72 hours after death with the Maryla t of Health and Mental hyglene. If item 27 Is marked other than "natural", or items 23e or 28e1 show or other traumatic event, I'm Modical Exemitent rast be notified at		19a. Informant's Name/Relationship (								Route Numbe				le)
	1 and Healt Healt Hear		Rosemary G. Fuchs 20a. Method of Disposition	, Daugnter	20b. P	Place of Dispo			aval	Quebe	ec, Car		cation - City		State
JOI L	ages ant of it: If it		1 ☐ Burial ②☐ Cremation 3 ☐ 1 ☐ Donation 5 ☐ Other (Speci		a	emetery, crer	natory or	other plac							
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or othar tra once.	ı	21. Signature of Funeral Service Like	_	THE	tro Cr	Name	and Address	s of Facility	,			timore	-	
ä	permi Depa Impo any ir		Thomas Grego			2	58ma	tion reder	Socie ick R	ty Of oad E	Maryl altimo	and	Inc. Marvl	and i	21228
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused one cause on each lir	the death	n. Do not ent	er the mo	de of dyin	g, such as c	cardiac or r	espiratory arr	est,		App	proximate erval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)	Cirrhosi	s of	the L	iver							Ons	set and Death
	/Medical Examiner		resulting in dealin)	Due to (or as	a consequ	uence of):									
		e	Sequentially list conditions, if any, leading to immediate	b. Due to (or as	a consequ	uence of):								-	
	uted d ansit	Examin	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	•											
o,	a exec an an rrial-tr	Exa	resulting in death) Last	Due to (or as	a consequ	uence of):									
8760,	cate be executed physician and the burial-transit	dical	•	d											
Θ	ertific ding p	/Mec	IF FEMALE:	22a Huan automa	-1										
Вох	death certifi e attending I id for use as	clan	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at	2 Fetal	Ideath 3□	Ectopic Other (s	oregnancy				2	23d. Date of o Month	felivery Day	Year
o.	0 0 0	ysic	1 Yes 2 No 9 Unknown	9☐ Unknown	time or de	54(1)	J Other (s	peciiy)							
ď.	requires that the death een signed by the atter hould be detached for u	by Physician/Me	Part II. Other significant conditions	contributing to death be	ut not resu	ulting in the u	nderlying	cause give	en in Part I.		23e. Did to	bacco u	se contribute	to the ca	use of death?
Records,	w require been sig should b	edt								_	1 🗆 Y	es 2	100 3 II	Probably	4 Unknown
ecc	≥ 0 N	ple									24a. Was a		24b. Were	autopsy f	indings available
_ 	Th ate pag	Completed									perfor	med?	geath 1 Y	es 2	
Vital	Physiclan: The lar this certificate has ral director, page 2	Be	25. Was case referred to medical examiner?	Hamilat.						of Death (	Check only or	re)			
of	Physical direction	To	Yes 2 No 27. Manner of Death	Hospital: 1 Inpatie		ER/Outpatien 28b. Time of			4   INUI:		5 Reside		Other (S	pecify) S	cene
on	ding Ph h. After thi funeral	tion	1 X Natural 5 ☐ Pending 2 ☐ Accident investigatio	(Month, Day	Year)	Injury	м	28c. Injury Work	rai ?? ∕es 2 🗍 N		d. Describe h	ow injury	occurred		
Division	of or Attending after death. Director: After din by the funer	ifica	3 Suicide 6 Could not be determined	e 28e. Place of Inju	ıry - At ho	me, farm, str					f. Location (S			Rural Rot	ıte Number,
Ö	tal or	Certification;	4   Homicide	building, etc	. (эрөспу	<i>(</i> )					City or Towi	n, State)	)		
	To the Hospital or Attentwithin 24 hours after death To the Funeral Diractor: completely filled in by the		(Uneck only 2 A Medical Exal	nysician: To the best of	examinat	wledge, death	occurre vestigatio	at the tim	e, date and	place, and	d due to the c	ause(s)	and manner	as stated.	cause(s)
	the thin 2 the mplet	Medical	29b. Signature and title of certifier	and manner sta	ted.			c. License							
	F X F 8		<b>&gt;</b> \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	halland	)		2	OCME					e signed (Mo		, sai)
	X MU		30. Name and address of person who	completed cause of d	eath (Item	23a) (Tyne	Print)				F	Apri	1 24 2	005	
	Pall		MARGARIA D	KORELL		(. jpd,		111	Penn S	Stree	t Bal	timo	re. Ma	ryla	nd 21201
Т	Sta Registr		31. Date filed (Month, Day, Year) APR 2, 8, 2005	32. Registra	r's Signar	ture	es .								

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** 1am Honie Graham HOL 3005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Initersity of Maryland Medical Center Battimore, Maryland If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 ☐ M 2 ☐ XF 70 Yrs. 214-64-1006 Director Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location Show 10b. County 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Maryla nent of Heath and Mental Hygiene. and to them the state of them 27 te marked other than "netural", or items 23a or 28a-4 show ury or other treumatic event. It is Marical Examplication at the motified at 1X Yes 2 No Baltimore Director Md. NA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21202 USA 1130 E. North Ave. 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: þ 3 Widowed 4 Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Sth grade (0-12) College (1-4or 5+) Family & Children Serv. Caretaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Taylor Emma Bridges James 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 504 Burgess Street, Lexington, N.C. Agnes Knotts Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department of Importent: If any injury or once. Voshell Mem. Garden 4-22-05 Dundalk, Md. 21. Signature of Funeral Service Licensee Baltimore, Md. 22. Name and Address of Facility March F.H. East 1101 E. North Ave. Wa 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Due to (or as a consequency of): Failure -month /Medical Examiner Due to (or s a consequence of): Sequentially list conditions, if any, leading to immediate cause. First Industrying Cause (Disease or injury that initiated events resulting in death) Last  $M \wedge M$ The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): Box 68760, attending physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Dav Year 4 Pregnant at time of death 5 Other (specify) P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 2 **2** No 3 ☐ Probably 4 ☐ Unknown Cancer Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 \( \text{Yes} \) 2 aryngeal Cancer 24a. Was an autopsy 1 Yes Hospitel or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 Yes 27 No Inpatient 2 ER/Outpatient 3 DOA this 28b. Time of Injury Certification: 27. Manner of Death 28d. Describe how injury occurred After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident after death Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral D 155. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2

DHMH 17 Rev 1/2001

Registrar

mo

Bathimore

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

J. Greene

APR 2 8 2005

31. Date filed (Month, Day, Year)

April 15, 2005

### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month GIESEY Day Year John, Henry 04 22 2005 11:13 AM 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) Johns Hophing Bagniew Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days 1 🕅 M 2□ F Months 218-22-8855 Yrs. 20, 1927 Maryland Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 X Yes 2 □ No Baltimore Maruland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4555 Hazelwood Avenue U.S.A. 21206 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S Armed Forces? 1 Myes 2 Norean If Yes, Give Conflict 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Specify: Specify: White 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Postal Service Special Deliveryman 12th Grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Giesey Charles С. Kuniguda J. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Jane A. Bittner (daughter) 4526 Fitch Avenue, Baltimore, MD 21236 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Buria! 2 □ Cremation 3 □ Removal from State Garrison Forest VA Cem. 10/29/05 Owings Mills, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Schimunek Funeral Homes 21. Signature of Funeral Service Ligensee 9705 Belair Rd., Baltimore, MD 21236 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) would to the head Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) MEDICAL Due to (or as a consequence of): CERTIFIC Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 Mo 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy

**Physician** /Medical Examiner

**Physician** 

/Medical

**Examiner** 

Directo

Funeral

þ

Completed

Be

**Funeral** 

Director

permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Important: If Item 27 is marked other then "reture!", or items 23e or 28e-1 ahrweny injury or other treuments event

Baltimore, Maryland 21215-0020

Examiner the attending physician and hed for use as the burial-transit signed b

The law requires that the death certificate be executed

at or Attending Physicien: The safter death.
I Director: After this certificate

To the Hospital or Atte within 24 hours after de To the Funeral Directo completely filled in by the

Division of Vital Records, P.O. Box 68760,

Physician/Medical ģ Completed Be ٩ Certification:

resulting in death) Last

25. Was case referred to medical 1₹Yes 2 No 27. Manner of Death

1 Natural 5 Pending investigation 2 Accident 6 Could not be determined 3 Suicide 4 Homicide

Hospital: 1 ☐ Inpatient 2 🗡 ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 22/05

28b. Time of Injury Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

8:19 AM

home

1 ☐ Yes 2 🔼 No

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

26. Place of Death (Check only one)

28d. Describe how injury occurre Subject shot self

1 Voe 2X No

28f. Location (Street and Number or Rural Route Number, City or Town, State) 4555 Haztewood Ave. Balt. HD 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number 18065 29d. Date signed (Month, Day, Year)

1 ☐ Yes 2 ☐ No

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Michael Eberlein, Johns Hopkins Bayview, 4940 Eastern Ave., Balt., MD 21224

Registrar

171

Medicai

29a. Certifier

31. Date filed (Month, Day, Year) APR 2 8 2005



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrer Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Elizabeth Elaine Genovese 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Balt ranklin Hospita seda Mare If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 ☐ M 2 🕱 F Yrs. Director 214-30-4378 Maryland Usual Residence of Decedent 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits rai', or itema 23a or 28e-f shov Examiner must be notified at 1 ☐ Yes 2X No Director Maryland Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 Brett Court, Apt 330 21221 u. s. A. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify 3 XWidowed 4 □ Divorced "natural" White other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry is marked other than Elementary/Secondary (0-12) College (1-4or 5+) 6th Grade Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 should be f and Mental F Robert List Katherine Kahler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: if item 27 ia m any injury or other traum once. Robert Genovese (Son) 715 Maryland Avenue, Essex, Maryland 21221 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4/28/2005 Baltimore, Maryland \* 4 ☐ Donation 5 ☐ Other (Specify) Most Holy Redeemer 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Home Inc. 3331 Brehms Lane, Baltimore, Maryland 21213 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence or): Examine Hospital or Attending Phyaician: The law requires that the death certificate be executed that initiated events resulting in death) Last attending physician and Due to (or as a consequence of): P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Year 4☐Pregnant at time of death 5 Other (specify) the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? 2 🗆 No 2/S No 1 Yes 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 1 ☐ Yes 2 No this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 2 Accident

Division of Vital Records,

After s after deu.
\*\*ai Director: Afte filled in by within 24 hours a To the Funeral C 2

29a. Certifier Medical (Check only one)

4 Homicide

29b. Signature and title of certified

6 Could not be determined

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | Medical Examiner: On the besis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

0061402

29d. Date signed (Month, Day, Year) 26

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Franklin 9000

APR 2 8 2005

are Drive

State

Registrar

ician		3.			Cei	riment of H	Jeani	2. Date of De	-		3. Time of Deat			
II GIGIL		. Decedent's Name (First, Middle,						Month	Day	Yeer				
dical		Betty Ma a. Fecility Name (If not institution,		Groves	-	4h City Town or	Location of Death	April	24	2005 County of Deeth	9:30 A			
niner		Knollwood Manor		11001)			sville		Anne Arunde					
al	5		. Sex	7. Age (In yrs.	last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Bir (Month, De	rth	9. Birth	place (State or For			
or		577-30-9745	1 ☐ M 2)(C) F	80	Yrs.	Months Days	Hours Min.	8-25-1	924	Col	WVA			
	-	Jsual Residence of Decedent  10a. State 10b. County		10c Cit	y, Town or Lo	cation					10d. Inside City Lin			
ō		MD Anne Aru	ında1		inthic						1 ☐ Yes 2 🛣			
Director	3	10e. Street and Number	inder			10f. Zip Code			10g. Citiz	en of What Cou	untry?			
ā	2	6843 B&A Blvd.				21090				USA	·			
Funeral	2 1	1. Marital Status	12. Was Dec	edent Ever in U	.S. 13.	Was Decedent of H	ispanic Origin? (Sp	ecify Yes or No	0- 1	4. Race - Amer				
Ē	2	1 ☐ Never Married 2 ☐ Married	Armed Ford  1 Tes If Yes, Gi	2 No		f Yes, specify Cuba 1 □ Yes 27☑ No	Specify:	Hican, etc.)		Black, White Specify: 7				
d b	2	3 ☑ Widowed 4 ☐ Divorced	Year or D	ates:			Specify.				white			
Completed	נו	15. Decedent's (Specify only highest	Education grade completed)		(Give	dent's Usual Occup kind of work done of DO NOT use retired	during most of work	ding .		IN HOME	ndustry			
GE C	2	Elementary/Secondary (0-12)	Coflege (	1-4or 5+)	1	omemaker	"			emaker				
ပိ		INK. 17. Father's Name (First, Middle, La	ast)				18. Mother's Nam	e (First, Middle	, Maiden S	Sumame)				
To Be	0	Lomer David Kel	L1y				Winifr	ed						
-		19a. Informant's Name/Relationship	p (Type, Print)		19b. Mailin	ng Address (Street	and Number or Ru	ral Route Numb	er, City or	Town, State, Z	ip Code)			
		Mr. R.Mike Muir/	nephew			Castle He	_	, Glen	Burni	le, MD 2	21061			
	2	20a. Method of Disposition 1 Ø Burial 2 ☐ Cremation 3	□ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □	20b. F	Place of Disponentery, crea	sition (Name of matory or other place	(a)	Date		cation - City or 1				
	+	Donation 5 Steer (Spe		Mea		lge Memor:	Lat	/2005		kridge,				
once. To Be Completed by Funeral Director		21. Signature Funeral Service Licensee 22. Name and Address of Facility Singleton Funeral Home P.A.  1 Second Ave SW Glen Burnie MD 21061  23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  Approximate												
		23a. Part1. Enter the disease, or c shock, or heart failure. List or	omplications that	caused the deat	th. Do not ent	er the mode of dyin	g, such as cardiac	or respiratory	arrest,		Interval Between			
an		fmmediate Cause (Final disease or condition	MI	TA ST	ATIC	. RECT	AL CA	RCINO	MA		Onset and Deat			
al er		resulting in death)	-	(or as a consec										
		Securitially list conditions b. Due to (or as a consequence of):												
iner	au e	if any, leading to immediate Due to (or as a consequence of):												
		Cause (Disease or injury	<b>\</b>	Cause (Disease or injury that initiated events c. resulting in death) Last Due to (or as a consequence of):										
Xan	Xan	Cause (Disease or injury that initiated events	c	(or as a consec	quence of):									
al Examin	al Exam	Cause (Disease or injury that initiated events	c. Due to	(or as a consec	quence of);									
edical	edical	Cause (Disease or injury that infitiated events resulting in death) Last	c. Due to	(or as a consec	quence of):									
edical	edical	Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant	d	tcome of pregn	ancy	□Ectopic pregnance	,		2	3d. Date of deli				
edical	edical	Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 \subseteq Yes 2 \subseteq No	d	tcome of pregnorth 2 ☐ Feta	ancy	⊒Ectopic pregnancy ] Other (specify)	,		2	23d. Date of deli Month	*			
edical	edical	Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 \( \subseteq Yes \) 2 No 9 \( \subseteq Unknown \)	d	tcome of pregni birth 2 □ Feta nant at time of d	ancy al death 3 [ death 5 [	Other (specify)		22a Did		Month	Day Year			
by Physician/Medical	by Physician/Medical	Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2  No 9  Unknown  Part If. Other significant condition	d	tcome of pregni birth 2 □ Feta nant at time of d	ancy al death 3 [ death 5 [	Other (specify)			tobacco us	Month se contribute to	Day Year			
by Physician/Medical	by Physician/Medical	Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2  No 9  Unknown	d	tcome of pregni birth 2 □ Feta nant at time of d	ancy al death 3 [ death 5 [	Other (specify)		1 🗆	tobacco us	Month se contribute to  No 3 □ Pre	Day Year the cause of death obably 4 Munkr			
by Physician/Medical	by Physician/Medical	Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9  Unknown  Part If. Other significant condition	d	tcome of pregni birth 2 □ Feta nant at time of d	ancy al death 3 [ death 5 [	Other (specify)		1 🗆 24a. Wa auto	tobacco us	Month se contribute to No 3 Pro 24b. Were au	the cause of death			
Completed by Physician/Medical	Completed by Physician/Medical	Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown  Part If. Other significant condition	d	tcome of pregni birth 2 □ Feta nant at time of d	ancy al death 3 [ death 5 [	Other (specify)	en in Part I.	1 □ 24a. Wa auto per 1 □ Yes	tobacco us Yes 2 [ s an opsy formed? 2 [J-No	Month se contribute to No 3 Pro 24b. Were au prior to codeath?	the cause of death			
Completed by Physician/Medical	Be completed by Physician/Medical	Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9  Unknown  Part If. Other significant condition  EMPHYS  25. Was case referred to medical examiner?	23c. If yes, our 1 Livie 4 Preg 9 Unkn	tcome of pregnipit 2 Fetanant at time of coown	ancy al death 3 [ death 5 [ sulting in the u	Other (specify)	en in Part I.  26. Place of Dea	1 ☐ 24a. Wa auto per 1 ☐ Yes	tobacco us Yes 2 [ s an ppsy cormed? 2 [ No one)	Month se contribute to No 3 □ Pro  24b. Were au prior to o death? 1 □ Yes	the cause of death obably 4 Munkr topsy findings avaisompletion of cause 2 No			
To Be Completed by Physician/Medical	lo Be Completed by Physician/Medical	Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Ves   2 No   9   Unknown  Part If. Other significant condition  Part If. Other significant condition  Part If. Other significant condition  25. Was case referred to medical examiner? 1   Yes   25 No   No   27. Manner of Death	d. 23c. If yes, or 1   Live 4   Preg 9   Unkr	tcome of pregnibith 2 Feta nant at time of clown	ancy al death 3 [ death 5 [ sulting in the u	Other (specify)	en in Part I.  26. Place of Dealer:	1 ☐ 24a. Wa auto per 1 ☐ Yes	tobacco us Yes 2 san ppsy ormed? 2 solo one)	Month se contribute to No 3 pro 24b. Were au prior to o death? 1 yes	the cause of death obably 4 Munkr topsy findings avaisompletion of cause 2 No			
To Be Completed by Physician/Medical	lo Be Completed by Physician/Medical	Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9  Unknown  Part If. Other significant condition  Part If. Other significant condition  25. Was case referred to medical examiner? 1  Yes 2 No	d	tcome of pregnionth 2 Fetanant at time of clown	ancy al death 3 [ death 5 [ sulting in the u	Other (specify)	en in Part I.  26. Place of Dealer:	24a. Wa auto per 1 U Yes th (Check only	tobacco us Yes 2 san ppsy ormed? 2 solo one)	Month se contribute to No 3 pro 24b. Were au prior to o death? 1 yes	the cause of death obably 4 Munkn topsy findings avairompletion of cause 2 No			
To Be Completed by Physician/Medical	lo Be Completed by Physician/Medical	Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown  Part If. Other significant condition  Part If. Other significant condition  25. Was case referred to medical examiner? 1  Yes 2 No  27. Manner of Death 1 Naturaf 5 Pending investign a Suicide 6 Could mit	d. 23c. If yes, out 1 Livie 4 Preg 9 Unkr	tcome of pregning to predict the common that time of common the common that th	ancy al death 3 [ death 5 [ sulting in the u  BER/Outpaties 28b. Time of Injury	Other (specify)	26. Place of Dea er: \$\frac{1}{2}\text{Nursing H} y at	24a. Wa auto per 1   Yes th (Check only ome 5   Res 28d. Describe	Yes 2 S an posy ormed? 2 No one) Sidence 6 how injury	Month  se contribute to  No 3   Product of the prior to death?  1   Yes  6   Other (Spector of Spector)  downward of Number of Ru	the cause of death obably 4 Munkm topsy findings avail completion of cause 2 No			
To Be Completed by Physician/Medical	lo Be Completed by Physician/Medical	Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes   2 No   9   Unknown  Part If. Other significant condition  Part If. Other significant condition  Part If. Other significant condition  25. Was case referred to medical examiner? 1   Yes   25 No    27. Manner of Death 1   Natural   5   Pending investigation   2   Accident   3   Suicide   6   Could not   1   1   1   1   1   1   1   1   1	d. 23c. If yes, out 1 Livie 4 Preg 9 Unkr	tcome of pregnicity of financial transfer of the company of the co	ancy al death 3 [ death 5 [ sulting in the u  BER/Outpaties 28b. Time of Injury	other (specify)  nderlying cause given the second of the s	26. Place of Dea er: \$\frac{1}{2}\text{Nursing H} y at	24a. Wa auto per 1   Yes th (Check only ome 5   Res 28d. Describe	tobacco us Yes 2 [ s an pormed? 2 [ No one) sidence 6	Month  se contribute to  No 3   Product of the prior to death?  1   Yes  6   Other (Spector of Spector)  downward of Number of Ru	the cause of death obably 4 24 Unkn topsy findings avail completion of cause 2 No			
To Be Completed by Physician/Medical	Certification: 10 Be Completed by Physician/Medical	Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes   2 No 9   Unknown  Part If. Other significant condition  Part If. Other significant condition  Part If. Other significant condition  25. Was case referred to medical examiner? 1   Yes   2 No   27. Manner of Death 1   Natural   5   Pending investig: nivestig: 1   No   28   Accident   3   Suicide   4   Homicide    29a. Certifier   1   Certifying	d. 23c. If yes, or 1   Live 4   Preg 9   Unkr. as contributing to of 2   A   Date (Moral ation of be 28e. Place build gray Physician: To the examiner: On the	tcome of pregning to pregning the property of the pregning to	ancy al death 3 [ death 5 [ sulting in the u  BER/Outpaties  28b. Time of Injury  nome, farm, st	other (specify)  nderlying cause given the second of the s	26. Place of Dearer: *** Nursing H y at k? Yes 2 \( \sum \) No	24a. Wa auto perful 1	tobacco us Yes 2 [ s an posy ormed? 2 [ No one) sidence 6 how injury (Street and own, State) e cause(s)	Month  se contribute to  No 3   Property of the contribute to death? 1   Yes  in Other (Specty occurred)  and manner as	the cause of death obably 4 Munkm topsy findings avail completion of cause 2 No			
To Be Completed by Physician/Medical	Certification: 10 Be Completed by Physician/Medical	Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	d. 23c. If yes, or 1   Live 4   Preg 9   Unkr. as contributing to of 28a. Date (Moral and and and and and and and and and and	Inpatient 2 of Injury of Injury of Injury th, Day Year) e best of my knoasis of examinations tasted.	ancy al death 3 [ death 5 [ sulting in the u  BER/Outpaties 28b. Time of injury nome, farm, st  owledge, deat attion and/or in	nderlying cause given the state of the state	26. Place of Dearer: Nursing H y at K? Yes 2 \( \sum \) No	24a. Wa autoperfile of the control o	Yes 2 s an posy ormed? 2 No one) sidence 6 how injury (Street and wn, State) e cause(s) , date and	Month  se contribute to  No 3 Pro  24b. Were au prior to c death? 1 Yes  Contribute to  A Number or Ru  and manner as place, and due	the cause of death obably 4 Munkn topsy findings avail completion of cause 2 No city)			
Certification: To Be Completed by Physician/Medical	Certification: 10 Be Completed by Physician/Medical	Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	d. 23c. If yes, or 1   Live 4   Preg 9   Unkr. as contributing to of 28a. Date (Moral and and and and and and and and and and	Inpatient 2 of Injury of Injury of Injury th, Day Year) e best of my knoasis of examinations tasted.	ancy al death 3 [ death 5 [ sulting in the u  BER/Outpaties 28b. Time of injury nome, farm, st  owledge, deat attion and/or in	nderlying cause given the state of the state	26. Place of Dearer: Nursing H y at K? Yes 2 \( \sum \) No	24a. Wa autoperfile of the control o	Yes 2 s an posy ormed? 2 No one) sidence 6 how injury (Street and wn, State) e cause(s) , date and	Month  se contribute to  No 3 Pro  24b. Were au prior to c death? 1 Yes  Contribute to  A Number or Ru  and manner as place, and due	the cause of death obably 4 Munking topsy findings avail completion of cause 2 No City)			
To Be Completed by Physician/Medical	Certification: 10 Be Completed by Physician/Medical	Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	d. 23c. If yes, or 1   Live 4   Preg 9   Unkr. as contributing to of 28a. Date (Moral and and and and and and and and and and	Inpatient 2 of Injury of Injury of Injury th, Day Year) e best of my knoasis of examinations tasted.	ancy al death 3 [ death 5 [ sulting in the u  BER/Outpaties 28b. Time of injury nome, farm, st  owledge, deat attion and/or in	nderlying cause given the state of the courred at the turn vestigation, in my course in 3.	26. Place of Dearer: Nursing H y at K? Yes 2 \( \sum \) No	24a. Wa autoperfile of the control o	Yes 2 s an posy ormed? 2 No one) sidence 6 how injury (Street and wn, State) e cause(s) , date and	Month  se contribute to  No 3 Pro  24b. Were au prior to c death? 1 Yes  Contribute to  A Number or Ru  and manner as place, and due	the cause of death obably 4 Manhar topsy findings avail completion of cause 2 No No Number, at the cause of t			

State of Maryland / Department of Health and Mental Hygiene [] [] 5 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** ANTHONY T. GASKINS 3:25 Apr 7, 2005 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** MD GENERAL HOSPITAL If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Days Hours 1 **X**M 2 □ F Yrs. Director 218-60-7259 Jun 20, 1955 MD Usual Residence of Decedent Pages 1 and 2 should ba filed within 72 hours after death with the Maryland nent of Health and Mental Hygjene. ant: If item 27 Ie markad other then "naturel", or Itams 23a or 28a-f ehow 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 27 le markad other then "naturel", or Itams 23a or 28a-f ehov treumetic event, the Madical Examiner must be nutilised at 1XYes 2 No **BALTIMORE** Director MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 1310 PENN AVE 21217 Completed by Funeral 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. I Tes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐xNo Specify: Black 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) DISPATCHER **EMT** 12 17 Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be GEORGIA WESTBROOK THEODORE GASKINS 10 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Department of Health a Importent: If item 27 Is any injury or other tre once. 805 SHIPFRIEND RD BALTIMORE, MD 21220 GASKINS Daughter CHANEL 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 3 ( Re noval from State 1 Burial 243 Cremation 04/21/05 BALTIMORE, MD 5 Other (Specify) **BAYVIEW CREMTORY** 4 □ Donation 22. Name and Address of Facility 21. Signature of Funeral 7, rvice Lices MILLER'S METROPOLITAN CHAPEL P.C 1639 N BROADWAY BALTIMORE MD 21213 or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Betw 23a. Part 1. Enter the disease heart failure. List only one cause Onset and Death mmediate Gause (Final e ROYIC a Raio VASULO. Physician disease or condition resulting in death) /Medical Examiner lax Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine use as the burial-transit Due to (or as a consequence of) the attending physician P.O. Box 68760 certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy Day Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No ò 4☐Pregnant at time of death 5 Other (specify) 9 Unknown detached þ 23e. Did tobacco use contribute to the cause of death? Part II, Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed Division of Vital Records, þ , page 2 should be 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate has 1 Yes X2 No 2 🗆 No Hospitel or Attending Physicien: funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 \sum Nursing Home Hospital: 2 ER/Outpatient 3 DOA 5 ☐ Residence 6 ☐ Other (Specify) 1 🗌 Yes 2 X No 1 X Inpatient this 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b Time of Certification: After 5 Pending investigation 1 🗷 Natural 1 ☐ Yes 2 ☐ No 24 hours after death. • Funerel Director: A 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical within 24 hor To the Fune completely fi (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 05 89541 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ROBERT CELLA MD GENERAL HOSPITAL BALTIMORE, MD 32 Registrar's Signature 31. Date filed (Month, Day, Year) State APR 2 8 2005 Registrar

DHMH 17 Rev 1/2001

ORIGINAL

05-2903 B.K.S CHARLES HECHT

Please Type or Print in Black Indelible Ink Figure All Copies Are Legible

ricuse Type of Francis Black Machine Mik. Endare An Copies 7	Ale Legible.	
State of Maryland / Department of Health and Mental Hyg	iene nn5	11
Certificate of Death	2000	6.

البالسالة			For State Registrer	State of Ma		partment of H Prtificate of I		Mental Hygie Reg.	4000	14396
	Dhuciai		1. Decedent's Name (First, Middle, Last	)				2. Date of Death	Day Year	3. Time of Death
	Physici /Medic	al	CHARLES		W.	HECHT		APRIL 2	26, 2005	3:31 P M
	Examin	er	4a. Facility Name (If not institution, give SINAI HOSPITAL	street and number)			CORE CITY		4c. County of Death	N/A
Ī	Funeral Director		22: 20 0000	X 2 F 7. Age	e (In yrs. last birthda 84 Yrs.	y) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth JAN . 1 , 1	9. Birthp Coul	olece (State or Foreign htty) KY
	land Sw		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or	Location				10d. Inside City Limits
	Mary a-f sho	tor	MD BALT	IMORE	BAL	TIMORE				1 ☐ Yes 2 🔀 No
	or 28	Director	10e. Street and Number			10f. Zip Code		10g	Citizen of What Coul	
	sath w		7 POMONA NORTH #	12. Was Decedent I	Ever in II C 45	Was Deceded of H	21208	posity Vas or No	14. Race - Americ	USA can Indian
920	d within 72 hours after death with the Maryland Jione. r than "natural", or Items 23s or 28s-f show The Medical Evantinet must be notified at	by Funeral	11. Marital Status  1 □ Never Married 2 ☑ Married  3 □ Widowed 4 □ Divorced	Armed Forces?  1 Ves 2 1  If Yes, Give Year or Dates:	NWII	3. Was Decedent of H If Yes, specify Cuba 1 Yes 2 No	Specify:	o Rican, etc.)	Black, White,	
Maryland 21215-0036	72 ho	Completed	15. Decedent's Ed	ucation de completed)	(Gi	cedent's Usual Occup ve kind of work done	during most of wor	king 16	b. Kind of Business/In	dustry
121	within ene. then	mpl	Elementary/Secondary (0-12)	College (1-4or 5	i+) life	. DO NOT use retired ESMAN	1)		INSTALLMEN	т
d 2	Hyg Hyg ent,	Be Co	17. Father's Name (First, Middle, Last)		JAL	LJIMI	18. Mother's Nan	ne (First, Middle, Mai		<u>'</u>
/lan	ರ್ಷದ ರಿ.	To B	ISAAC		HEC	HT	EDITH			MILLER
Man	2 6 2 9	4	19a. Informant's Name/Relationship (7 FLORENCE HECHT /			iling Address (Street and NORT			ity or Town, State, Zip	Code)
	1 an Heal em 2 ther		20a. Method of Disposition	MILE	20b. Place of Dis	position /Name of	1		c. Location - City or To	own, State
<u>o</u> E	Page ent c nt: M		1 X Burial 2 ☐ Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Specify		1	rematory or other place LOH CEMETE		8/2005	WOODLAWN	, MD
Baltimore,	permit. Page Department Importent: any injury once.		21. Signature of Funeral Service Licen	7.0		22. Name and Addres	ss of Facility SO	L LEVINSO	N & BROS., KESVILLE,	
			23a. Part1. Enter the disease, or companies shock, or heart failure. List only of	olications that caused one cause on each li		enter the mode of dyin				Approximate Interval Between
	Pnysician	2 4	Immediate Cause (Final disease or condition resulting in death)	a. Com	licoted	by Cles	tord H	ead on	iurés	Onset and Death
	/Medical Examiner		ſ	Due to (or s	a consequence of):		<i>*</i>	,	F	
		ner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying	Due to (or as	a consequence of):					
	tificate be executed ig physician and as the burial-transit	Examine	Cause (Disease or injury that initiated events resulting in death) Last	C. Duo to (or as	a consequence of);			· · · · · · · · · · · · · · · · · · ·		
68760,	be ex sician burial			Dag (0 (0) 43	a consequence on).					
687	ifficate g phys as the	ledicai		d						
.O. Box	The faw requires that the death certif ate has been signed by the attending page 2 should be detached for use a	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome  1 Live birth  4 Pregnant at 9 Unknown	2 Fetal death	3 □Ectopic pregnancy 5 □ Other (specify)	,		23d. Date of delive Month	ery Day Year
s, P	w requires that i been signed by should be deta	by	Part II. Other significant conditions of	ontributing to death b	ut not resulting in the	underlying cause giv	en in Part I.		cco use contribute to t	
of Vital Record		Completed						24a. Was an autopsy performe 1 \( \text{Yes} \) 2	prior to co	opsy findings available impletion of cause of
Vita	Physiclan: Th r this certificate ral director, pag	o Be	25. Was case referred to medical examiner?  1 🏋 Yes 2 □ No	Hospital: 1 ☐ Inpatie	ent 2 ER/Outpat	ient 3☐ DOA Oth	or	ath (Check only one)	S Dobes (Sassi	4.1
	g Physier this eral dir		27. Manner of Death	28a. Date of Inju	ry 28b. Time	of 28c. Injur			e 6 Other (Special Conjury occurred	(y)
sior	ending Feath. or: After	catlo	1 □ Natural 5 □ Pending  S □ Accident investigation  3 □ Suicide 6 □ Could not be	4/261	05 144		Yes 2 No	briveria	acto ac	udent
Division	Hospitel or Attending 24 hours after death. Funerel Director: After itely filled in by the fune	Certification;	3 Suicide 6 Could not be 4 Homicide determined	289/ Place of III	ury - At home, farm, c. (Specify)	street, factory, office		28f. Location (Street City or Town, S	et and Number or Run State)	al Route Number,
	To the Hospitel within 24 hours a To the Funerel I completely filled	edical			f examination and/or				se(s) and manner as s and place, and due t	
	To the within To the comp	Me	29b. Signature and little of certifier	7 ~		29c. Licens			. Date signed (Month,	*
)	6		1 ( Work	em)		OC	ME	A	APRIL 27, 2	2005
	10		30. Name and address of person who	cke, in	eath (Item 23a) (Typ	111 Penn	Street	Baltimore	, Maryland	1 21201
	Sta Regist	ate rar	31. Date filod (Month, Day, Year) APR 2 8 2	32. Angistr	ar's Signature	Sparle				

DHMH 17 Rev 1/2001

**ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3 Time of Death **Physician** 2005 Year APRTI. 25, 1650 Рм James Johnson /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner ANNE ARUNDEL 131 LAKESHORE ROAD **PASADENA** | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | 9. Birthplace (Months Days Hours Min. | Nov 19, 1944 Tenn. 5. Social Security Number 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months 1 X M 2 □ F 60 218-42-4664 Yrs. Director Usual Residence of Decedent with the Maryland 10c. City. Town or Location 10a State 10b. County 10d. Inside City Limits rel', or Items 23e or 28e-f show Examiner aust be notified at Md. Anne Arundel Pasadena 1 ☐ Yes 2X No Completed by Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 131 Lake Shore Dr. 21122 USA Pages 1 and 2 should be filed within 72 hours after death 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ▼No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: White Specify: Widowed 4 ☐ Divorced "neturel", 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 9th Truck Driver Tractor Trailer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be and Mental H James Leland Johnson Mae 2 Adams 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Importent: If item 27 Is eny injury or other treu once. 131 Lake Shore Dr. Pasadena Md. 21122 Lena J. Menzel (Sister) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Metro Crematory 4/26/05 Balt. Md. ^ 4 □ Donation 5 □ Other (Specify) 22. Name and Address of FacilityStallings Funeral Home PA 21. Signature of Funeral Jervin, Licensee 3111 Mountain Rd. Pasadena, Md. 23a. Part 1. Enter the disease, or do plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heartifailure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician emdiovascular Atherosclerotic disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury Due to [or as a cons \* uence of ]: Examiner and I-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) sician a burial Box 68760. Physician/Medical attending physi IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day 4☐Pregnant at time of death 5 Other (specify) P.O. the 9 Unknown 9 Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. à 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?
1 ☑ Yes 2 ☐ No certificate 1 Yes 2 🗆 No To the Hospitel or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 1 X Yes 2 □ No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) SCENE 10 this 28a. Date of Injury (Month, Day Year) After thi funeral 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27 Manner of Death Certification: 1 Watural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident within 24 hours after deat To the Funerel Director: filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2X Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 26, 2005 Mi, mud APRIL OCME

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year) APR 2 8 2005

LING

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Mid

Registrar's Signature

111 Penn Street

Baltimore, Maryland 21201

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death April 25, 2005 Year **Physician** 7:00 a M Phyllis Jacobson /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore 2 Waterway Court, Apt. 1-D Towson 7. Age (In yrs. last birthday)
7. Age (In yrs. last birthday)
7. Age (In yrs. last birthday)
7. Age (In yrs. last birthday)
7. Age (In yrs. last birthday)
7. Age (In yrs. last birthday)
7. Age (In yrs. last birthday)
7. Age (In yrs. last birthday)
7. Age (In yrs. last birthday)
7. Age (In yrs. last birthday)
7. Age (In yrs. last birthday)
7. Age (In yrs. last birthday)
7. Age (In yrs. last birthday)
7. Age (In yrs. last birthday)
7. Age (In yrs. last birthday)
7. Age (In yrs. last birthday)
7. Age (In yrs. last birthday)
7. Age (In yrs. last birthday)
7. Age (In yrs. last birthday)
7. Age (In yrs. last birthday)
7. Age (In yrs. last birthday)
7. Age (In yrs. last birthday)
7. Age (In yrs. last birthday)
7. Age (In yrs. last birthday)
7. Age (In yrs. last birthday)
7. Age (In yrs. last birthday)
7. Age (In yrs. last birthday)
7. Age (In yrs. last birthday)
7. Age (In yrs. last birthday)
7. Age (In yrs. last birthday)
7. Age (In yrs. last birthday)
7. Age (In yrs. last birthday)
7. Age (In yrs. last birthday)
7. Age (In yrs. last birthday)
7. Age (In yrs. last birthday)
7. Age (In yrs. last birthday)
7. Age (In yrs. last birthday)
7. Age (In yrs. last birthday)
7. Age (In yrs. last birthday)
7. Age (In yrs. last birthday)
7. Age (In yrs. last birthday)
7. Age (In yrs. last birthday)
7. Age (In yrs. last birthday)
7. Age (In yrs. last birthday)
7. Age (In yrs. last birthday)
7. Age (In yrs. last birthday)
7. Age (In yrs. last birthday)
7. Age (In yrs. last birthday)
7. Age (In yrs. last birthday)
7. Age (In yrs. last birthday)
7. Age (In yrs. last birthday)
7. Age (In yrs. last birthday)
7. Age (In yrs. last birthday)
7. Age (In yrs. last birthday)
7. Age (In yrs. last birthday)
7. Age (In yrs. last birthday)
7. Age (In yrs. last birthday)
8. Age (In yrs. last birthday)
8. Age (In yrs. last birthday)
8. Age (In yrs. last birthday)
8. Age (In yrs. last birthday)
8. Age (In yrs. last birthday)
8. Age (In yrs. last birthday)
8. Age (In yrs. last birthday)
8. Age (In yrs. last birthday)
8. Age (In yrs. last birthday) 5. Social Security Number **Funeral**  Birthplace (State or Foreign Country) 1 ☐ M 2 🖫 F 220-20-6057 Director Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene.

ant: If item 27 Is marked other than "neturel", or items 23e or 28e-f show 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits other traumatic event, the Medical Exert instriust be notified at Completed by Funeral Director 1 ☐ Yes 2 X No Baltimore Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21286 2 Waterway Court. Apt 1-D U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. ☐Yes 2☐No Yes, Give 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: If Yes, Give Year or Dates: Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Assistant Computer Analyst AAI Corp 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Mary Emanuel Elmer Rosier Belle Cumminas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Henry Jacobson, Jr. -Husband 2 Waterway Ct., Apt 1-D, Towson, MD 20b. Place of Disposition (Name of cemetery, crematory or other place)

Dulaney Valley Mem'l Gard 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages
Department of
Importent: If it
eny injury or o 1 € Burial 2 Cremation 3 Removal from State 4/28/05 Timonium, MD \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Icensee 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. William G. Dau 1050 York Rd., Towson, MD 21204 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Filysician disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner or Attending Physicien: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): P.O. Box 68760, the attending physician hed for use as the buria IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year 4☐Pregnant at time of death 5 Other (specify) ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has 17 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner Other: 4 Nursing Home 202 No ٩ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 □Other (Specify) this the funeral 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28d. Describe how injury occurred After 1 Injury 5 Pending death. 1 ☐ Yes 2 ☐ No investigation after death Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) yd ni bellii 4 Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) within 2 29b. Signature 29d. Date signed (Month, Day, Year) 2 2 State APR 2 8 2005 Registrar

			For State Registrar	State of M	larylan				eaith a D <i>eath</i>	nd Me		iene	05	4400
			1. Decedent's Name (First, Middle, Las	st)						2	. Date of Deat Month	h Day	Year	3, Time of Death
	Physicia /Medic		James Ke	ilholtz						F	)pril	23	2005	5:50 p.m.
	Examin		4a. Facility Name (If not institution, give					_	Location of				unty of Death	
			North Hrundt						If Under 2		5		re ARI	
	Funeral		5. Social Security Number 6. S 219-22-6197	ex 7.A (X) M 2 □ F	ge ( <i>in yrs.</i> i 77	last birthday) Yrs.	Months	r 1 Year Days	Hours	Min.	Date of Birth (Month, Day OC 05	Year)	9. Birthp	place (State or Foreign htry) MD
	Director		Usual Residence of Decedent								<i>Jec.</i> 03	1567		110
	/land		10a. State 10b. County		10c. City	y, Town or Lo	cation						1	0d. Inside City Limits
	Many Interior	to	Maryland Anne A	runel				Pas	adena					1 ☐ Yes 2 📉 No
	as or 286	i Director	10e. Street and Number 762 Bridge Driv	е			10f. Zi	p Code	211	22	1	0g. Citizer	of What Cour USA	ntry?
38	be filed within 72 hours after death with the Maryland ital Hyglene. Id other than "natural", or Items 23a or 28a-f show other than "natural", or Items 13a or 28a-f show event, the Medical Examinar must be molified at	by Funeral	11. Marital Status  1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Deceden Armed Forces 1 X Yes 2 Lif Yes, Give Year or Dates	? ] No		Was Dece f Yes, spo 1 🗆 Yes	cify Cuba	ispanic Orig n, Mexican, Specify:	in? (Speci Puerto Ric	fy Yes or No- can, etc.)		Race - Americ Black, White, Wh	
Š	2 ho	ted	15. Decedent's E			16a. Dece	dent's Usi	al Occup	ation	of working		16b. Kind	of Business/In	dustry
215	e. en "n	npie	Elementary/Secondary (0-12)	College (1-40)	5+)				during most	or working				
21	filed withi Hygiene. other then	Completed	8			Р	last	ic Mo		d- N (	Circh Middle A		tingho	use
Maryland 21215-0036	S d a S	To Be	17. Father's Name (First, Middle, Last, James Keilhol						I da		First, Middle, M	Maiden Su	mame)	
	d 2 s th ar th ar treu		19a. Informant's Name/Relationship ( Mary D. Keilholtz		se)						dena, M			Code)
altimore,	nit. Pages 1 and artment of Healt ortent: If item 2' injury or other g.		20a. Method of Disposition 1 □ Burial 2 🖸 Cremation 3 □	Demouslifrom Stat	20b. F	Place of Dispo emetery, crea	sition (Na natory or	me of other plac	e) A	pri Pat	23		tion - City or To	
Ĕ	Pages nent of I		'4 □Donation 5 □ Other (Special		Met	tro Cre	emato	ry I	nc.	2005	b	altir	nore, M	aryland
Balt	permit. Pages 1 an Department of Heal Importent: If item 2 any injury or other once.		21. Signature of Funeral Service Lice	Seed					ss of Facility Itain		talling Pasad			Home, P.A. 22
			23a. Part. Enter the disease, or comshock, or heart failure. List only	one cause on each	line.	h. Do not ent	er the mo	de of dyin	g, such as	cardiac or r				Approximate Interval Between Onset and Death
8760,	Physician /Medical Examiner physician and physician and physician and the prival-transit	dical Examiner	disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Coro Due to (or a	erte	NSion		Dis	seasc	ar e				
O. Box 6	The law requires that the death certific ate has been signed by the attending page 2 should be detached for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcom 1 Live birth 4 Pregnant 9 Unknown	2 🗌 Feta	al death 3	Ectopic	pregnancy				230	I. Date of delive Month	ery Day Year
Δ.	res that igned by be deta	by Pr	Part II. Other significant conditions	contributing to death	but not res	sulting in the u	nderlying	cause giv	en in Part I.		127	-4		he cause of death?
ord	w require been si should I	eted									1 □ Ye	-		posy findings available
I Rec		Completed									autops	y		mpletion of cause of
/ita	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:				O+	or		Check only on			
1	hysi this c	P	1 ☐ Yes 2 No	1 ZNnpa		ER/Outpatie			4 🗆 140		9 5 Reside			fy)
n c	After unera	on:	27. Manner of Death  1 Natural 5 Pending	28a. Date of Ir (Month, L	Day Year)	28b. Time o Injury	M	28c. Injur Wor	yat k? Yes 2∐1		d. Describe ho	w injury o	ccurred	
Division of Vital Records,	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director,	Certification:	2 Accident investigation 3 Suicide 6 Could not I 4 Homicide determined	28e. Place of	njury - At h etc. (Speci				163 2		f. Location (St City or Town		Number or Rura	al Route Number,
	e Hospite 24 hours a Funerel letely fillec	Medical C	29a. Certifier 1 Certifying P (Check only one) 2 Medical Exa	hysicien: To the be miner: On the basis and manner	of examina	owledge, deal ation and/or in	h occurre	d at the tir	ne, date an pinion, dea	d place, an	d due to the call at the time, d	ause(s) ar ate and pl	nd manner as s ace, and due t	stated. o the cause(s)
	To th within To th	Me	29b. Signature and title of certifier				2	c. Licens	e number				signed (Month,	
	0		Hom Fr	Arci Ms				002	741	5	1	Jen	l 23, 2	2005
ļ	011.		30. Name and address of person who HENRY FRANCE	completed cause o		m 23a) (Type The A	Print)		Hospi	ta/				
	St	ate	31. Date filed (Month, Day, Year)		strar's Sign		and a							

DHMH 17 Rev 1/2001

Keilholtz, IAMes

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

			1 - For State Ragistrar	State of Maryland		t of Health a e <i>of Death</i>	nd Mental Hygie	4000	14401
	Physici	an	Decedent's Name (First, Middle, Last)		Vi		2. Date of Death Month	Day Year	3. Time of Death
	/Media	al	4a. Facility Name (If not institution, give s		Koch	Town, or Location of	April 2	1 2005	735 AM
	Examin	er	The Johns Hopk	ins Hospital	But	timore (	<u>ity</u>	4c. County of Dear	n 
	Funeral Director		5. Social Security Number 6. Sex 1 S	M 2□F 7. Age (In yrs. last 37	birthday) If Under Months	1 Year If Under 2 Days Hours	Min. 8. Date of Birth (Month, Day, You 12-30 -6	ear) Co	hplace (State or Foreign untry) RYLAND
	Maryland -1 show	tor	10a. State 10b. County	UNDEL 10c. City, To	own or Location EVERN				10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	with the	Director	10e. Street and Number		10f. Zip	Code	10g	Citizen of What Co	untry?
	death ms 23	Funerai	7733 TELEC	12. Was Decedent Ever in U.S.	13. Was Deced	lent of Hispanic Orig	in? (Specify Yes or No- Puerto Rican, etc.)	14. Race - Ame	ncan Indian.
036	nit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland adment of Heath and Mental hygiene. ortent: If item 27 is marked other then "naturel" or items 23a or 28e-1 show injury or other traumatic event, the Medical Examinar must be notified at injury or other traumatic event, the Medical Examinar must be notified at 8.8.		1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces?  1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	If Yes, spec		Puerto Rican, etc.)	Black, White	
15-0	n 72 ho "natul edical	leted	15. Decedent's Educ (Specify only highest grade	cation 16 completed)	6a. Decedent's Usua (Give kind of wor	Il Occupation rk done during most se retired)	of working 161	o. Kind of Business/	Industry
21215-0036	filed withi Hygiene. other then	Completed by	Elementary/Secondary (0-12)	College (1-4or 5+)	SEMBLY"	TECNICI		CATIONA	REHAB
Maryland	should be fill nd Mental Hy marked oth imatic event	To Be	17. Father's Name (First, Middle, Last)			47	s Name (First, Middle, Mai	den Sumame) NEK	
Mary	12 shouh and N	_	19a. Informant's Name/Relationship (Type		9b. Mailing Address	(Street and Number	or Rural Route Number, C	ity or Town, State, Z	
	es 1 and 3 of Health fitem 27 r other tr		20a. Method of Disposition		of Disposition (Namitery, crematory or of	ne of	EN BLENIE M Date 200	. D · Z l O 6 . Location - City or	
Baltimore,	permit. Pages 1 al Department of Hea Importent: If item any injury or othe once.		1 ☑ Burial 2 ☐ Cremation 3 ☐ Ro 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	ETERANS CE	METERY L	1-28-05 C	eownsvil	IE, MD.
Ball	permit. Departm Importer any inju		21. Signature of Europeration License		22. Name and	d Address of Facility  Daughert	/ Family Funeral Home 01 Mountain Road - Pa	And Cremation C	enter, P.A.
Π			23a. Part1. Enter the disease, a complication of the shock, or heart failure. List only on	ations that caused the death. De cause on each line.	o not enter the mode	of dying, such as c	ardiac or respiratory arrest,	Maria Maria	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a consequence	Druir	1 In	jury		9 Days
	Examiner		Sequentially list conditions, b.	Hypoal	v c'emi	a			10 Days
J	uted d ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to Nr as a conseduend	te of):				/-
. '09	ificate be executed g physician and as the burial-transit		resulting in death) Last	Due to (or as a consequence	e of):				
68760,	fficate to physical p	edicai	<b>V</b> d.						
Вох	eath certifi attending for use as	an/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	Bc. If yes, outcome of pregnancy 1 Live birth 2 Fetal dea	ith 3 □Ectopic pre	egnancy		23d. Date of deli	*
0	w requires that the death cer been signed by the attendir should be detached for use	Completed by Physician/M	1 Yes 2 No 9 Unknown	4 ☐ Pregnant at time of death 9 ☐ Unknown	5 ☐ Other (spe	ecify)		Month	Day Year
S, D	es that igned b	by P	Part II. Other significant conditions conf	A			23e. Did tobace	co use contribute to	
ord	requir	eted	Enc stage	Renai D	iseas-	e	1 Yes		bably 4 Unknown
Vital Records,	The law te has	ompl	Parchee!	Vosculur	n: 4	2. 60	24a. Was an autopsy performed	prior to c death?	opsy findings available ompletion of cause of
/ita	clen: ertifica sctor, p	BeC	25. Was case referred to medical examiner?		0136	26. Place o	1 ☐ Yes 2 ☑ f Death (Check only one)	No 1 □ Yes	2 No
of \	Physic this call dire	၉	1 ☐ Yes 2 No Ho 27. Manger of Death		Outpatient 3 DO/		ing Home 5 Residence		ify)
on	nding ath. r: After e funer	ation	1 Vatural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	Time of 28	3c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how in	njury occurred	
Division of	el or Atte s after des l Directo d in by th	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, building, etc. (Specify)	farm, street, factory,	office	28f. Location (Street City or Town, St		al Route Number,
	To the Hospitel or Attending Physicien: The law requires that the death cert within 24 hours after death.  To the Funerel Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use a	Medical C	29a. Certifying Physi (Check only one)	ician: To the best of my knowled er: On the basis of examination a and manner stated.	ge, death occurred a and/or investigation,	it the time, date and in my opinion, death	place, and due to the cause occurred at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier		29c.	License number	29d.	Date signed (Month	Day, Year)
•			yer lly	MD		T4539	8	Apr 22	2005
	1		30. Name and address of person who cor	npleted cause of death (Item 23a	#	More M	1 21287		
	Sta	-	31. Date filed (Month, Day, Year)	32. egistrar's Signature			-160/		

		•	For State Registrar	State of Maryland		artment tificate					iene	)5		02
	Physicia	an I	1. Decedent's Name (First, Middle, Last)							Date of Deat Month	Day	Year	3. Time of	
	/Medic	al	Frank Russell			41. 02. 3				oril	25, 2	005	0.00	P M
	Examin	er	4a. Facility Name (If not institution, give st 4313 Camellia Ro					Location of more	of Death		,	imor imor		
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. la	ast birthday)	If Under	1 Year	If Under	24 Hrs. 8.	Date of Birth	1		place (State ontry)	or Foreign
	Director		213-16-3734 1X	M 2□F 83	Yrs.	Months	Days	Hours	Min.	(Month, Day,	1921	Ma	ryland	
	pr .		Usual Residence of Decedent  10a. State 10b. County	10c. City	, Town or Lo	cation		_					10d. Inside C	ity Limits
	Aaryla f sho	ō	Maryland Baltimor			3altin	naho							2 17 No
	the N	Directo	10e. Street and Number			10f. Zip				10	Og. Citizen of \	What Cou	ntry?	
	23e or		4313 Camellia Ro	ad				21236	;		и.	s.A.		
	ems ?	Funerai	11. Marital Status	2. Was Decedent Ever in U.S Armed Forces?	S. 13. V	Was Deced	ent of Hi	spanic Ori	igin? (Specify	Yes or No- an, etc.)		e - Amen	ican Indian, , etc.	
36	s afte	by Fu	1 Never Married 2 Married 3 Widowed 4 Divorced	1 MaYes 2 □ No If Yes, Give Year or Dates: WW 11	.   1	1 ☐ Yes 2	No X	Specify:			Specif	r: Wh	ite	
8	filed within 72 hours after death with the Maryland Hygiene. Hygiene naturel; or Items 23e or 28e-f show ant. Ite Maulical Examination notified at	ed b	15. Decedent's Educi		16a. Decec	ient's Usua	l Occupa	ation			16b. Kind of B	usiness/lr	ndustry	
75	hin 72	plet	(Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4or 5+)	life. L	DO NOT us	e retired,	)	st of working				tainle	<b>SS</b>
21	giene giene er the	Completed	6th Grade		Sa	teel v	vork				Steel			
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.  Department of Health and Mental Hygiene.  Department of Health and Mental Hygiene.  And The Marylan Hygiene are the maryland to the them any injury or other treumatic event. Its Maruical Exams are must be notified at ODGE.	To Be	17. Father's Name (First, Middle, Last) Frank A. King							irst, Middle, M Chr	Maiden Suman istie	16)		
lary	2 shou and N is mai		19a. Informant's Name/Relationship (Typ			-					City or Town,	State, Zi	p Code)	
e)	l and lealth om 27 ther tr		Gary R. King ( 20a. Method of Disposition	son)	0010 ace of Dispo			aa, b	Baldwir Date	-	21013 20c. Location -	City or T	own State	
Jor	ages nt of 1 t: If ite		1 X Burial 2 ☐ Cremation 3 ☐ Re	moval from State	metery, cren	natory or ot	her place		1/28/2		3altimo			nd
Ħ	nit. P artme orten injury		*4 □ Donation 5 □ Other (Specify)  21. Signature of Fundam Service License								-uneral			., tet
Ba	Departing any ir		· (ht/W)							_	MD 21			
			23a. Part 1. Enter the disease, or complic shock, or heart failure. List only one	ations that caused the death e cause on each line.	. Do not ent	er the mode	e of dying	g, such as	cardiac or re	spiratory arre	est,		Approxima Interval Be	tween
9	Physician		Immediate Cause (Final disease or condition		ardia	l gr	lar	chou					Onset and	
	/Medical Examiner		resulting in death)	Due to (or as a gonsequ	0 1		0						200	100
4		e	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequ	ence of):	sion							20 7	tais
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	Transitio	mal 1	Cell	Co	wan	of,	Kidne	y		6yea	
oʻ	an an arial-tr		resulting in death) Last	Due to (or as a consequ	ence of):				0	4			1/2	
8760,	death certificate be executed e attending physician and of for use as the burial-transit	Physician/Medical	d.											
9 X	death certifica attending ph d for use as th	/Me	IF FEMALE: 23	Sc. If yes, outcome of pregnar	ncy						23d. Da	te of deliv	/erv	
Вох	atten I for u	cian	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	1 Live birth 2 Fetal 4 Pregnant at time of de	death 3	]Ectopic pro] ] Other (sp						onth		Year
P.O.	that the de ed by the detached	hysi	9 Unknown	9 Unknown	-									
	uires that signed b d be det	by	Part II. Other significent conditions conf	tributing to death but not resu	Ilting in the u	nderlying ca	ause give	en in Part I	l.		pacco use conf es 2 □ No	tribute to 3 □ Pro		death? Kinknown
Vital Records,	law requires as been sign 2 should be	Completed								24a. Was a		Were aut	opsy findings	available
Re	9 4 9	omp								autops perform	ned?	death?	ompletion of a 2□No	cause of
ta	ilclen: Th certificate rector, pag	a)	25. Was case referred to medical					26. Place	e of Death (C	heck only on				
of V	× 5 0	To B	examiner? 1 Yes 2 No		ER/Outpatier						nce 6 Oth		ity)	
o u	ding P. After ti funera	on:	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury		8c. Injury Work			I. Describe ho	w injury occur	red		
Division	Attending r death. ector: After by the fune	icat	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - At ho	me farm str	M reet factory		Yes 2□		Location (St	reet and Numb	oer or Rui	al Route Nur	nber,
DIV	or Attendated death Director:	Certification:	4 ☐ Homicide determined	building, etc. (Specify	7)	cot, lactory	, 011100			City or Town	, State)			
	To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	edical C	29a. Certifier 1 Certifying Phys (Check only one)	ician: To the best of my knower: On the basis of examinat and manner stated.	wledge, deatl ion and/or in	h occurred vestigation,	at the tim	ne, date ar pinion, dea	nd place, and ath occurred	I due to the ca at the time, d	ause(s) and ma ate and place,	anner as and due	stated. to the cause(	s)
	To the within 2 To the complet	Med	29b. Signature and title of certifier	warran make to de		290	. License	e number		2	9d. Date signe	d (Month	, Day, Year)	
•	- > - 0		Meeta Cou	Pali MD		$ \mathcal{I} $	009	540	34		Abril 2	7, 2	2005	
	441		30. Name and address of person who con	10 A 10	1 /	Print)		.200			1			
	()		31. Date filed (Month, Day, Year)	Road, 15 au 32. Projistrar's Signal		141	) 2	1630						
	Sta Regist	ate rar	APR 2 8 20	105 Bener	K A	redi	9							

			State of Maryland / Der State of Maryland / D	artment of Health and N per me G843 5-19-0 rtificate of Death	lental Hyg 5 tas	giene 005 14403
ı	Physic	an	1. Decedent's Name (First, Middle, Last)  SHARON KEARNEY		2. Date of Dea Month APRIL	Day Year
-	/Medi Examir		4a, Facility Name (If not institution, give street and number) 1515 OAKRIDGE ROAD	4b. City, Town, or Location of Death	ALKIL	26, 2005 6:50a M
				BALTIMORE CITY		NA
55	Funeral Director		5. Social Security Number    6. Sex   1   M 2 M F   7. Age (In yrs. last birthday   42   Yrs.	If Under 1 Year   If Under 24 Hrs.   Months   Days   Hours   Min.	8. Date of Birth (Month Day 03 · 15 ·	(Year) 9. Birthplace (State or Foreign Country) MD
,	laryland show		10a. State 10b. County 10c. City, Town or I			10d. Inside City Limits
	the Ma	Director	MD NA BALTIMO			1 ☑ Yes 2 ☐ No
	th with 1 23a or 3	I Dir	1515 OAKRIDGE ROAD	10f. Zip Code 21218		10g. Citizen of What Country? USA
36	er dea	by Funeral	11. Marital Status  1 Marital Status  1 Marital Status  1 Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 Yes 2 No If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.
5-00	72 hours "netural",	eted	15. Decedent's Education 16a. Dec	dent's Usual Occupation a kind of work done during most of work	ina	16b. Kind of Business/Industry
Maryland 21215-0036	2 should be filed within and Mental Hygiene Is marked other than "eumatic event, the Mark	Completed	Elementary/Secondary (0-12) 12 TH GRADE 4 College (1-4or 5+) PHARI	DO NOT use retired)	ung :	MEDICINE
and	d be fill anta! Hy ed oth	Be	17. Father's Name (First, Middle, Last) CLIFFORD JOHNSON	18. Mother's Nam	e (First, Middle, . PARKE	Maiden Surname)
aryl	should and Men s marke umatic	은		ing Address (Street and Number or Rur		
	and 2 lealth a m 27 ls				-	mo. 21223
Baltimore,	permit. Pages 1 and 2 should I popartment of Health and Men Important: If item 27 is marker any injury or other treumatic. once.		'4 □ Donation 5 □ Other (Specify)  WESTERN	matory or other place)		20c. Location - City or Town, State BA너O · MI)
Ball	permit. Departe Import any inj			2. Name and Address of Facility IUGHN C. GREENE FUN 151 BALTO. NATL PIKE		
	Physician /Medical		23a. Part1. Enter the disease, or complications that caused the death. Do not enshock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. Cardiac Arrythmia  Due to (or as a consequence of):			Onset and Death
	Examiner	er	Sequentially list conditions			
	and I-transit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.			
8760,	sate be executed by sician and the burial-transit	dical Ex	resulting in death) Last  Due to (or as a consequence of):  d.			
9	certifica anding ph use as th	a a	IF FEMALE:			
P.O. Box	The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Completed by Physician/M		□Ectopic pregnancy □ Other (specify)		23d. Date of delivery  Month Day Year
	w requires that been signed I should be det	ed by P	Part II. Other significant conditions contributing to death but not resulting in the	inderlying cause given in Part I.		bacco use contribute to the cause of death? es 2 No 3 Probably 4 Unknown
Vital Records,	The law reate has be page 2 sho	Complet			24a. Was a autops perform	sy prior to completion of cause of
Vita	ysician: The is certificate hadirector, page	Be	25. Was case referred to medical examiner?  Hospital:	26. Place of Deat		ne)
	g Phys er this eral di	n: To	27. Magner of Death 28a. Date of Injury 28b. Time	TRE SEL DON   4   INDISTINGTIO		ence 5XXOther (Specify) ow injury occurred
sion	Attending Physician: r death. actor: After this certifics by the funeral director.	atlo	2 Accident investigation	M 1 Yes 2 No		
Division of	tel or Att rs after de al Diracte ed in by tl	Certification:	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury - At home, farm, s building, etc. (Specify)	reet, factory, office	28f. Location (St City or Town	treet and Number or Rural Route Number, n, State)
	To the Hospitel or Attenwithin 24 hours after deatl To the Funeral Director:	Medical	29a. Certifier (Check only one)  1☐ Certifying Physician: To the best of my knowledge, dea 2☑ Medical Exeminer: On the basis of examination and/or is and manner stated.	h occurred at the time, date and place, ivestigation, in my opinion, death occurr	and due to the cared at the time, d	ause(s) and manner as stated. ate and place, and due to the cause(s)
	To the within 2 To the comple	Σ	29b. Signature and title of certifier  2011 July 2016	29c. License number  OCME		APRIL 26, 2005
			30. Name and address of person who completed cause of death (Item 23a) (Type		ot D-1:	-imore M11-04004
	Sta	ite	31. Date filed (Month, Day, Year) 32. Agistrar's Signature APR 2 8 2005	111 Fenn Stre	et Balt	timore, Maryland 21201
Di	Regist		APR 2 8 2005	18 A.		

		1 - For State Registrar	State	of Maryla	-	artment of F rtificate of		nd Menta	l Hygier	-	[: 1 - 1	
q		1. Decedent's Name (First, Middle	, Last)					2. Date	e of Death	Day Year		of Death
Physic /Med		Frederick	W		F	Kraska		Apr		2005	4:45	5 A M
Exami		4a. Facility Name (If not institution	give street and n	umber)		4b. City, Town, o	Location of [	Death	1	4c. County of De	ath	
		715 Oakleigh Be	ach Road			Dunda				Baltim	ore	
Funera Director		5. Social Security Number 213–07–8567	6. Sex 1 X M 2 □ F	7. Age (In yrs	s. last birthday) 3 Yrs.	If Under 1 Year Months Days		Min. (Mo	of Birth oth, Oay, Yea y 25, 1	9. B 901 G	rthplace (State Sountry) ermany	or Foreign
P .	1	Usual Residence of Decedent		1100 5	NA Town	4!					104 1-14	0
aryta shov	<u>_</u>	10a. State 10b. County	mana	į	City, Town or Lo Dundalk						10d. Inside	S 2 X No
he M	ecto	MD. Balti	WOTE		Duiluair		- <del></del>		10- 4	0 hi 1 hall 1 o		
with t	Dir	10e. Street and Number	ach Dond			10f. Zip Code	222		10g. (	Citizen of What C USA	ountry?	
s 23	era	715 Oakleigh Be		cedent Ever in	118 121	Was Decedent of H		n? (Specify Ve	e or No-	14. Race - An	encan Indian	
ter d	Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Marri	Armed F		0.3.	f Yes, specify Cuba	an, Mexican, F	Puerto Rican, e	etc.)	Black, Wh		
hours after death with the Maryland hours after death with the Maryland turel; or Items 23e or 28e-f show all Exertified at	by	3 Widowed 4 Divorced	If Yes, G Year or	ive		1☐ Yes 2🛣 No	Specify:			Specify: W	hite	
2 hou	ted	15. Decedent	's Education	<i>n</i>	16a. Dece	dent's Usual Occup	ation	of considers	16b.	Kind of Busines	s/Industry	
within 72 ene. Then "ne	Completed	(Specify only highes Elementary/Secondary (0-12)		(1-4or 5+)	life.	kind of work done DO NOT use retired	d) d)	or working				
A will	Son	12 years			Carr	enter				nstruct	ion	
d be filed ontal Hygic ed other c event, II	Be (	17. Father's Name (First, Middle,	Last)					s Name (First,				
laryland CICI 2 should be filled within and Mental Hygiene. Is marked other the. eumatic event, the M.	2	Wilhelm Kraska						ia Wane				
INTEXTIGITION ZIZIONUSO  Is 1 and 2 should be filed within 72 hours after death with the Marylar of Health and Mental Hygiene. Item 27 is marked other then "neturel", or Items 23e or 28e-f show other treumatic event, the Marylan Exertitien is a tast to nutified at		19a. Informant's Name/Relationsh	nip (Type, Print)	con		ng Address (Street						
te, IV 1 and 1 Health tem 27		Karl Kraska  20a. Method of Disposition		son		akleigh I		1000	_	Location - City of		
permit. Pages 1 Department of H Importent: If ite any njury or ot once.	1	Burial 2 Cremation		n State	cemetery, crer	natory or other plac		April 2	9,			
DESILITION Sernit. Pages Department of Importent: If it iny njury or o		' 4 ☐ Donation 5 ☐ Other (Si		Cn		theran Ce	, ,	2005		ndalk,M		
Department of the contract of		21. Signare e di Fulledal Service i	ICHISHO M	1.000		Name and Addre	Funera.	1 Home	Of Dur	ndalk,P.	A.	. )
	Ė	23a. Part! Enter the disease or shock, or heart failure. List	complications that	caused the dea	ath. Do not ent	7110 Soll	ers Po. ng. such as ca	INT ROS	atory arrest.	idalk, Md	Approxim	ate
-200.3		shock, or heart failure. List Immediate Cause (Final	only one cause on	each line.	9	-,, .			,,		Interval B Onset and	
Ph sician /Medical		disease or condition resulting in death)	a	HD	augan of						5.	year,
Examiner			Oue it	o (or as a conse	equence or):						2	years
	ē	Sequentially list conditions, if any, leading to immediate	b. Due to	o (or s a conse	equence of):	19					-	DONS
d ansit	Examin	cause. Enter Underlying Cause (Discase or injury that initiated events	· A-	trial	Fib	Mati	CAC				3	
O, o exect an an an an rial-tr		resulting in death) Last	Due to	(or as a conse	equence of):					-		
icate be executed physician and the burial-transit	dical		d									
ortifica ing pl	a a	IF FEMALE:									An.	
death certif death certif e attending ad for use as	Physician/M	23b. Was decedent pregnant in the past 12 months?	1 Live	utcome of preg birth 2 ☐ Fe	ital death 3	Ectopic pregnancy	/			23d. Date of de Month	elivery Day	Year
the a	ysic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4⊟Preg 9⊟Unk	gnant at time of nown	death 5L	Other (specify) _			_			
The colors, r.O. box of The law requires that the death certificate has been signed by the attending page 2 should be detached for use as		Part II. Other significant condition	ns contributing to	death but not re	esulting in the u	nderlying cause giv	en in Part I.	236	a. Did tobacci	o use contribute	to the cause of	death?
sign d be	d by		-						1 🗌 Yes	2 □ No 3 □ F	robably 4	Unknown
wrequires been sign	Completed	4						24:	a. Was an	24b Were a	autopsy finding	s available
25 8 8	dm								autopsy performed?	prior to death?	completion of	cause of
VICAL iclen: Ti certificate ector, pa	e Co	25. Was case referred to medical					26 Place of	1 Death (Check		Vo 1 ☐ Ye	s 2 <b>½</b> No	
OI VIIA Physiclen: rthis certific ral director,	O B	examiner?	Hospital:	Inpatient 2[	☐ ER/Outpatier	nt 3 DOA Oth	or		à l	6 ☐Other (Sp	ecify)	
	-	27. Manper of Death	28a. Date	e of Injury onth, Day Year)	28b. Time of				-	jury occurred	oony,	
Vitending death. ctor: Afte y the fune	atlo	1 Natural 5 ☐ Pendin 2 ☐ Accident investig	9	ilili, Day 10al)	Injury		Yes 2□No	0				
VIS Atte	tific	3 Suicide 6 Could r	ned 288. Plac	ce of Injury - At ding, etc. (Spec	home, farm, str	eet, factory, office			ation (Street or Town, Sta	and Number or F	Rural Route Nu	mber,
s affe	Certification;			anny, ata. (apac								1
To the Hospitel or Attending within 24 hours after death. To the Funerel Director: Afte completely filled in by the fune funerel presence.	edical	(Check only 2 Medical				occurred at the tirvestigation, in my o						(s)
the hin 24 the F	Medi	one)	and ma	nner stated.		29c. Licens						
5 time 100	~	29b. Signature and title of certifier	n	SI	M		3 4 C	57	29a. L	Date signed (Mor	) ( ) ( L	, >
							) (	-	10,	T   6 11		
111		30. Name and address of person	111	use of death (Ite	1 11-		ANE	D.	1+0	110	2005	277
[U	ate	31. Date filed (Month, 1945, Year)	n, M. D.	gistrar's Sign	nature	labird	_1100		4110		, 010	-66
Regis		APR 2 8	2005	Koka	K A	reek !						

Jung Jae Kim 05-02858 d1

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	For	State of Maryland / Department of Health and Mental	Hygier
-	State Registrar	Certificate of Death	Reg. I

Physician	
/Medical	
Examiner	

Funera Directo

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or itams 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

Physician /Medica Examine

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit

Division of Vital Records, P.O. Box 68760,

	•	For State Registrar		,	Certificate of Death Reg. No.							
		1. Decedent's Name (First, Middle, La	st)					2. Date of Month	Death Day	204	-	3. Time of Death
ciar dica		Jong Jae	Kim						1 24,			11:45 A
ine		4a. Facility Name (If not institution, give	e street and number)			4b. City, Town, or	Location of De	eath	4c.	County of [	Death	
		305 Main Street				Laurel			Pr	ince (	Geor	ge's
al or		5. Social Security Number 6. S 217-13-4531	ex 7. Aç X M 2□F	ge (In yrs. last birt) 59 Y	rs.	Months Days	If Under 24 H Hours N		Day, Year)		Birthpla Count Kore	• •
		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town	orto	cation					10	d. Inside City Limits
,	5			, roon only, round	0, 20,							1 ☐ Yes 2 X No
Director	2	Maryland Montgo  10e. Street and Number	mery			Burton 10f. Zip Code	sville		10a. Citi	zen of Wha	t Count	rv?
Z	5	4001 Wood Swallov	Court			20866				Korea		
Firegra	5	11. Marital Status	12. Was Decedent	Ever in U.S.	13. V	Vas Decedent of Hi	ispanic Origin?	(Specify Yes or		14. Race - /	America	n Indian,
	3	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 🔯	?	İ	Yes, specify Cuba	n, Mexican, Pu	ierto Rican, etc.)		Black, V	White, e	tc.
1	2	3 ☐ Widowed 4 ☑ Divorced	If Yes, Give Year or Dates:		1	☐ Yes 2☐XNo	Specify:			Specify:	As	ian
3	3	15. Decedent's Ed		16a. Decedent's Usual Occupation						ess/ind	ustry	
Completed	2	(Specify only highest gra		(Give kind of work done during most of working life. DO NOT use retired)								
1 8	5	12	College (1-4or		De1	ivery Per	rson		Dry	7 Clea	nin	g
	υİ	17. Father's Name (First, Middle, Last)			-	18. Mother's i	Name (First, Midd	lle, Maiden	Surname)			
a c		Jae Hong Kim				Mye	ong Hi K	im				
II.		19a. Informant's Name/Relationship (	Type, Print)	19b.	Mailin	g Address (Street a	and Number or	Rural Route Nun	nber, City o	r Town, Sta	te, Zip (	Code)
		Do Ya Kim/Sister		4(	001	Wood Swa	allow Co	ourt Bu	rtons	ville	, MI	20866
		20a. Method of Disposition	16 000	cemeten	Dispos	sition (Name of natory or other place	θ)	Date	20c. Lo	cation - City	y or Tow	n, State
		1 ☐ Burial 2 X Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Specify		Metro	Cre	matory,	Inc. 4	/27/05	Ba1	timor	e, N	ID .
현		21. Signature of Funeral Service Licer	1500			Name and Addres						
3	Ì	Edward A. Gree	orchik		1 20	99 Freder	ick Ros	ad Baltir	nore.	MD 21	228	
		23a. Part 1. Enter the disease, or com shock, or heart failure. List only	plications that cause	d the death. Do n	ot ente	er the mode of dying	g, such as card	diac or respiratory	arrest,	10		Approximate Interval Between
		Immediate Cause (Final	m. Oti	-00 mis	ra v	or and	anno	ostima	Varia	na mi	a	Onset and Death
i		disease or condition resulting in death)	a. 1. Due to (or as	consequence o	f):	4 000	J	2000	1	Jan		
r												
i i	5	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as	a sonséquance o	ij.							
Evaminer		that initiated events	c									
		resulting in death) Last	Due to (or as	a consequence o	f):							
Modical	3		_ d	•								
2		<u></u>										
		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	of pregnancy 2 Fetal death	3□	Ectopic pregnancy			2	23d. Date of		
100	2	in the past 12 months? 1  Yes 2 No	4☐Pregnant a 9☐ Unknown			Other (specify)				Month		Day Year
Completed by Dhysician/	Ė	9 Unknown		-								
2	2	Part II. Other significant conditions of	ontributing to death t	out not resulting in	the un	iderlying cause give	en in Part I.					cause of death?
1	2							- 1	Yes 2	<b>25.</b> No 3 [	] Proba	bly 4 Dunknown
100	2						_	24a. Wi	as an topsy	24b. Were	e autop:	sy findings available pletion of cause of
8	5							pe 1 X Yes	rformed?	deat	h?	!□ No
Ba	2	25. Was case referred to medical examiner?					26. Place of 0	Death (Check onl				
F		1 Yes 2 No	Hospital: 1 Inpati	ent 2 ER/Out	atient	t 3□ DOA Othe	er: 4 🗆 Nursin	g Home 5 🗆 Re		,		
						28c. Injury Work	at c?	28d. Describ	e how injun			
100	1	1 Natural 5 Pending investigation	7-6-1	1017 140		Yes 2 □ No	erushe	dun			chine	
191	3 ☐ Suicide 4 ☐ Homicide  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  28f. Location (Street and Number or Rural Route Number, City or Town, State) ○ ← Cub To 10 CM U.C.									Route Number,		
9	27. Manner of Death    Natural							305 Ma				
0	2	29a. Certifier 1. Certifying Ph	ysician: To the best niner: On the basis o	of my knowledge,	death	occurred at the time	ne, date and pla	ace, and due to th	e cause(s)	and manne	r as sta	ted. he cause(s)
0	3	one)	and manner st	ated.								
3	=	29b. Signature and title of contifier	/ MA			29c. License	number			e signed (M		
		NA Clark	(11)	. ,	OCME			April 25, 2005			5	
		30. Name and address of person who	completed cause of	death (Item 23a) (1	ype, f	Print)						

State Registrar 31. Date filed (Month, Day, Year) APR 2 8 2005

32. Registrar's Signature

111 Penn Street, Baltimore, Maryland 21201

Mya N. Kinard Please Type or Print in Black Indelible Ink Ensure All Copies Are Legible. unpend item#23a-b,27, perHk. 6844,6729/05 TT State of Maryland / Department of Health and Mental Hygiene in E 05-02802 For State Registrar Certificate of Death Reg. No. RJ 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Appril 21° **Physician** Mya N. Kinard 2003 8:19 Pm /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Sinai Hospital Baltimore City N/A If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Pays Hours Min. Fe Month Pay, Year 005 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country)
 MD **Funeral** 1□ M 2 F 218-71-4053 Yrs. Director Usual Residence of Decedent with the Maryland 10b. County N / A 10a. State 10c. City, Town or Location 10d. Inside City Limits r then "natural", or items 23a or 28e-f show the Medical Examiner must be notified at Baltimore MD 14 Yes 2 No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2508 N. Edgecombe Cir. Apt. I 21215 United States within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ∑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race · American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Black 1 ☐ Yes 2 No Specify: Baltimore, Maryland 21215-0036 Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) N/ACollege (1-4or 5+) N/A other treumatic event, 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) nd Mental I Lapaul Kinard Denise Bamberg Pages 1 and 2 should be ment of Health and Menta tent: If item 27 is marked 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Wanda Bamberg-Grandmother 2508 N. Edgecombe Cir. Apt. I Balto MD 21215 20b. Place of Disposition (Name of cemetery, crematory or other place) Apr Date 28 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) permit. Page Department o Importent: ff. any injury or 5 Baltimore, MD. Bayview Crematory 2005 21. Signature of Funeral Service Licensee Calvin L. Willy iams Functal Service, P.A. alvini Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Sepsis /Medical Due to (or as a consequence of): Examiner Bilateral Otitis Media Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, by Physician/Medical the as IF FEMALE: use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 3 Ectopic pregnancy Month Day detached for 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. pe 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

125 Yes 2 \sum No page 2 s autopsy performed? 1 Yes 2 No 25. Was case referred to medical examiner?
1 🗗 Yes 2 🗌 No funeral director. Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 9 3□ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: After 1 XNatural 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No 2 Accident the 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide within 24 hours after de To the Funerel Directo completely filled in by th 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospitel 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of ce OCME April 22, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 Penn Street Baltimore, MD. 21201 31. Date filed (Month, Day, Year) 32. egistrar's Signature

State

Registrar

2005

State of Maryland / Department of Health and Mental Hygiene 1 - For Stata Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Day Month Edward Lowman /Medical April 25 2005 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Deeth 551 Leelyn Drive Severna Park Anne Arundel If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year) April 05 1933 7. Age (In yrs. last birthday) **Funeral**  Birthplace (State or Foreign Country) 219-30-5186 1 X M 2 ☐ F Director Yrs. MD Usual Residence of Decedent the Maryland 10a. State 10b. County r than "natural", or Itams 23a or 28a-f show the Medical Examinant the notified at 10c. City. Town or Location 10d. Inside City Limits Director Maryland Anne Arundel Severna Park 1 ☐ Yes 2 ☑ No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? with 551 Leelyn Drive 21146 death 1 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes ≥ □ No 1953 — If Yes, Give Year or Dates: 1955 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Pages 1 and 2 should be tiled within 72 hours atter nand of Healin and Mental Hygiene.

Int. I item 27 is marked other than "natural", or Italy or other traumatic evant, the Mealine Evanting. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 þ 1 ☐ Yes 2 ☑ No Specify: 3 XWidowed 4 ☐ Divorced White 1955 Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 5+ <u>Civil Engineer</u> Civil 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Russell Lowman Ester Shannon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rich L. Lowman (son) 551 Leelyn Drive, Severna Park, MD 21146 20a. Method of Disposition 20b. Place of Disposition (Name of cametery, crematory or other place) Aprilate 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. 4 □ Donation 5 □ Other (Specify) Hillcrest Cemetery 2005 Annapolis, Maryland vice Lir ensee 21. Signature A Funeral S 22. Name and Address of Facility Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD 21122 mulications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, by one cause on each line. 23a. Part 1. Enter the disease, or c shock, or heart failure. List or Immediate Cause (Final disease or condition resulting in death) Physician PANCREATIC months /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) The law requires that the death certiticate be executed Due to (or as a consequence of): Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death Month Day Year 5 Other (specify) Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? perform 1 Yes 2 No 1 ☐ Yes 2 ☐ No or Attanding Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28d. Describe how injury occurred Atter 1 Natural after death. investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital of within 24 hours at To the Funaral D completely tilled i Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number MD D24532 April 26,2005

3a) (Type, Print)

22 South GREEN& St. Beltimore, Md 21201 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 01 EXHO, MIS

DHMH 17 Rev 1/2001

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** April <sup>Day</sup> 22, Scott Dane LaRicci 3:35p м 2005 /Medical 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 705 Philadelphia Road Joppa Harford If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Months Days Hours Min. May9, 1958 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral**  Birthplace (State or Foreign Country) 1 XM 2 ☐ F 218-72-0969 Director 46 Maryland Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 28a-f show 10d. Inside City Limits traumatic evant, the Modical Examiner must be notified at MD Harford Directo Joppa 1 ☐ Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 705 Philadelphia Road or itams 23a 21085 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Pages 1 and 2 should be filed within 72 hours after Black, White etc. 1 Never Married 2 Married 1 ☐ Yes 2X No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 Tes XXNo þ Specify: 3 Widowed 4 Divorced Specify:White "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Dish Network Self-employed h and Mental Hygier 7 is markad other th 8th 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) Anthony LaRicci Naomi J.Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: if Item 27 is any injury or other traignes. Linda Dells /sister 705 Philadelphia Road Joppa MArylan d 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State BayviewCrematory 4/26/05 <sup>4</sup> □ Donation 5 □ Other (Specify) Baltimore M D 21. Signature of Funeral Service Licensee 22. Name and Address of Facility ConnellyFuneralHomeofEssex Baltimore MD 21221 300 Mace Ave. 23a. Part1. Enter the disease, or combications that caused the death. Denet enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician SQUAMOUS CELL CARCINOMA SUPRAGLOTTIS resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leaving Laure cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a nonsequence of) Hospital or Attanding Physician: The law requires that the death certificate be executed use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ģ in the past 12 months? Day Year 4☐Pregnant at time of death P.O. 5 Other (specify) 9 Unknown 9 Unknown Š Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ 3 Probably 4 □Unknown funeral director, page 2 should Be Completed 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed?
1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 2 🗀 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 12 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending death. investigation after death 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral L 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) auroustoner MO D16619 30. Name and a dress of person who completed cause of death (Item 23a) (Type, Print) C. VERGARA- SOZRES 9940 FRANKLIN BALTIMORE MD. 21236 SOMARE DRIVE

DHMH 17 Rev 1/200

State

Registrar

32. sistrar's Signature

2 8

2005

	_	For State Registrar		Department of I Certificate of	Death	Reg	. No. 2 0 0 5	44
Physicia	an l	1. Decedent's Name (First, Middle, L	•			2. Date of Death Month	Day Year	3. Time of Dea
/Medica		Jessie A. L					4. 2005	12:45A
Examine		4a. Facility Name (If not institution, g		1	or Location of Death	•	4c. County of Death	
		Stella Maris Hos			Lmonium		Baltimor	e County
uneral irector		5. Social Security Number 6. 216-10-2084	Sex 1 □ M X ▼ F 7. Age (In yrs. last bit	rthday) If Under 1 Year Months Days		B. Date of Birth (Month, Day, Ye		place (State or For intry)
		Usual Residence of Decedent	104			June 23,	1900   Mar	yland
r 28a-f ahow	jo	Maryland 10b. County	/A	m or Location Baltimore				10d. Inside City Lir 1XX Yes 2 □
or 28a	Completed by Funeral Director	10e. Street and Number		10f. Zip Code	01011	10g.	Citizen of What Cou	intry?
nust I	erai	299 W. 31st Stree	12. Was Decedent Ever in U.S.	12 Was Dansdard of L	21211	4. V	US	
or Itan	Fun	1 XXNever Married 2 ☐ Married	Armed Forces? 1 ☐ Yes X2X No	13. Was Decedent of H If Yes, specify Cub		ny Yes or No- ican, etc.)	14. Race - Ameri Black, White,	can Indian, , etc.
Important: If item 27 is marked other than "natural", or Itams 23a or any injury or other traumatic avent, Ita Medical Examinationual becomes	d by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	1 ☐ Yes 2/CXNo	Specify:			white
Medic	piete	15. Decedent's I (Specify only highest g Elementary/Secondary (0-12)	rade completed)  College (1-4or 5+)	<ul> <li>Decedent's Usual Occup (Give kind of work done life. DO NOT use retire)</li> </ul>	ation during most of working d)	7	o. Kind of Business/Ir	ndustry
ar tha	E C	unknown	Conege (1-401 5+)	Machinis	st	A	American C	an Co.
vent	e	17. Father's Name (First, Middle, Las	st)		18. Mother's Name (			
atica	To E	Burton Lohr			Jennie Al	.ban		
27 is m traum	-	19a. Informant's Name/Relationship Ellsworth Hudson		28 Pinewood				
ther other	-	20a. Method of Disposition					e, Marylan	
or of		X⊠Burial 2 □Cremation 3	☐Removal from State	f Disposition (Name of ry, crematory or other place	(4)		. Location - City or To	
njur)	-	* 4 □ Donation 5 □ Other (Spec 21. Signature 1 Funeral Service Like		ine Park Cem	, =	•	odlawn, M	aryland
any ir		21. Signatural Funeral Service Lice	- A	Burgee-Hen	ss of Facility SS-Seitz F	uneral H	lome, Inc.	
	-	23a Part 1 Enter the disease or our	Chiperitic	JUST LUTTE	i⊥NOau bai	Fimore.	Marviand	
			nplications that caused the death. Do r y one cause on each line.	not enter the mode of dyir	g, such as cardiac or i	respiratory arrest,		Approximate Interval Between
sician		Immediate Cause (Final disease or condition resulting in death)	a DEMENTIA				1	Onset and Deat
edical miner		resulting in death)						
			Due to (or as a consequence	of):				
	_	Sequentially list conditions,	b					
	liner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a consequence of Due to (or as a consequence of					
	xaminer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. — Due to (or as a consequence of	of):				
	Ĭ.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of it jusy that initiated events resulting in death) Last	b	of):				
ysician and ne burial-transit	ical Ex	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of it jusy that initiated events resulting in death) Last	b. — Due to (or as a consequence of	of):				
ysician and ne burial-transit	ical Ex	IF FEMALE:	b. Due to (or as a consequence of Due to (or as a consequence of d	of):			23d Date of delive	200
attending physician and for use as the burial-transit	ical Ex	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	b. Due to (or as a consequence of Due to (or as a consequence of d.	of):  3 □Ectopic pregnancy			23d. Date of delive Month	ery Day Year
attending physician and for use as the burial-transit	ical Ex	IF FEMALE: 23b. Was decedent pregnant	b. Due to (or as a consequence of Due to (or as a consequence of d.  23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death	of):				*
ed by the attending physician and detached for use as the burial-transit	Physician/Medical Ex	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	b. Due to (or as a consequence of Due to (or as a consequence of d.  23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death	of):  3 □Ectopic pregnancy 5 □ Other (specify) □	en in Part I.	23e. Did tobacc		Day Year
igned by the attending physician and be detached for use as the burial-transit	by Physician/Medical Ex	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	b. Due to (or as a consequence of Due to (or as a consequence of d.  23c. If yes, outcome of pregnancy 1	of):  3 □Ectopic pregnancy 5 □ Other (specify) □	en in Part I.	23e. Did tobacc 1 ∐ Yes	Month co use contribute to the	Day Year
igned by the attending physician and be detached for use as the burial-transit	by Physician/Medical Ex	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	b. Due to (or as a consequence of Due to (or as a consequence of d.  23c. If yes, outcome of pregnancy 1	of):  3 □Ectopic pregnancy 5 □ Other (specify) □	en in Part I.	1 ☐ Yes	Month  co use contribute to th	Day Year  ne cause of death  pably 4 XUnkno
has been signed by the attending physician and ge 2 should be detached for use as the burial-transit	by Physician/Medical Ex	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	b. Due to (or as a consequence of Due to (or as a consequence of d.  23c. If yes, outcome of pregnancy 1	of):  3 □Ectopic pregnancy 5 □ Other (specify) □	en in Part I.	1 ☐ Yes 24a. Was an autopsy	Month  co use contribute to the contribute to the contribute to the contribute to the contribute to the contribute to the contribute to contribute to contribute to contribute to contribute to contribute to contribute to the contribute to contri	Day Year  ne cause of death pably 4 XUnkno
sale has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Completed by Physician/Medical Ex	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ▼ No 9 □ Unknown Part II. Other significant conditions	b. Due to (or as a consequence of Due to (or as a consequence of d.  23c. If yes, outcome of pregnancy 1	of):  3 □Ectopic pregnancy 5 □ Other (specify) □		1 Yes  24a. Was an autopsy performed 1 Yes 2 X	Month  co use contribute to the contribute to the contribute to the contribute to contribute to contribute to contribute to contribute to contribute to contribute to contribute to contribute to contribute to contribute to contribute to contribute to contribute to contribute to contribute to contribute to the contribute to contribute t	Day Year  ne cause of death pably 4 X Unknown psy findings availampletion of cause
sale has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Be Completed by Physician/Medical Ex	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ▼ No 9 □ Unknown  Part II. Other significant conditions	b. Due to (or as a consequence of Due to (or as a consequence of Due to (or as a consequence of d.  23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown contributing to death but not resulting in	of):  3   Ectopic pregnancy 5   Other (specify)	26. Place of Death ((	1 Yes  24a. Was an autopsy performed 1 Yes 2 X	Month  co use contribute to th	Day Year  ne cause of death pably 4 X Unknown psy findings availampletion of cause 2 \( \) No
this certificate has been signed by the attending physician and all director, page 2 should be detached for use as the burial-transit	To Be Completed by Physician/Medical Ex	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	b. Due to (or as a consequence of c. Due to (or as a consequence of d. 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown contributing to death but not resulting in Hospital:	of):  3   Ectopic pregnancy 5   Other (specify)	26. Place of Death ((	1 Yes  24a. Was an autopsy performed 1 Yes 2 1 1 Check only one) 5 Residence	Month  co use contribute to th	Day Year  ne cause of death pably 4 X Unknown psy findings availampletion of cause 2 \( \) No
this certificate has been signed by the attending physician and all director, page 2 should be detached for use as the burial-transit	To Be Completed by Physician/Medical Ex	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	b. Due to (or as a consequence of Due to (or as a consequence of Due to (or as a consequence of d.  23c. If yes, outcome of pregnancy 1   Live birth 2   Fetal death 4   Pregnant at time of death 9   Unknown  contributing to death but not resulting in	of):  3   Ectopic pregnancy 5   Other (specify)    the underlying cause given  to the underlying cause given	26. Place of Death (t)  30. 4 Nursing Home  4 at 286	1 Yes  24a. Was an autopsy performed 1 Yes 2 X	Month  co use contribute to th	Day Year  ne cause of death pably 4 X Unknown psy findings availampletion of cause 2 \( \) No
tor: After this certificate has been signed by the attending physician and the funeral director, page 2 should be detached for use as the burial-transit certifier. To Be Completed by Dhymician Addition Exercises	To Be Completed by Physician/Medical Ex	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	b. Due to (or as a consequence of Due to (or as a consequence of Due to (or as a consequence of d.  23c. If yes, outcome of pregnancy 1   Live birth 2   Fetal death 4   Pregnant at time of death 9   Unknown  contributing to death but not resulting in the pregnant at time of death   Hospital: 1   Inpatient 2   ER/Out   28a. Date of Injury (Month, Day Year)   In the pregnance of	of):  3   Ectopic pregnancy 5   Other (specify)    the underlying cause given  tipatient 3   DOA   Other  time of 28c. Injury   Work M 1   Total	26. Place of Death /(  3r: 4 □ Nursing Home  4 at 286  27  4 □ No	24a. Was an autopsy performed 1 Yes 2 1 Check only one) 5 Residence d. Describe how in	Month  2  No 3  Prob  24b. Were auto prior to cor death? 1  Yes  6  Other (Specification)	Day Year  ne cause of death' pably 4 1 Unknown  psy findings availampletion of cause 2 No  HOSPICI
tor: After this certificate has been signed by the attending physician and the funeral director, page 2 should be detached for use as the burial-transit certifier. To Be Completed by Dhymician Addition Exercises	To Be Completed by Physician/Medical Ex	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2 X No 9   Unknown  Part II. Other significant conditions  25. Was case referred to medical examiner? 1   Yes 2 X No 27. Manner of Death 1 Natural 5   Pending investigation	b. Due to (or as a consequence of Due to (or as a consequence of Due to (or as a consequence of d.  23c. If yes, outcome of pregnancy 1   Live birth 2   Fetal death 4   Pregnant at time of death 9   Unknown  contributing to death but not resulting in the pregnant at time of death   Hospital: 1   Inpatient 2   ER/Out   28a. Date of Injury (Month, Day Year)   In the pregnance of	of):  3   Ectopic pregnancy 5   Other (specify)    the underlying cause given  tipatient 3   DOA   Other  time of 28c. Injury   Work M 1   Total	26. Place of Death /(  3r: 4 □ Nursing Home  4 at 286  27  4 □ No	24a. Was an autopsy performed 1 Yes 2 1 Check only one) 5 Residence d. Describe how in	Month  20 use contribute to th	Pay Year  ne cause of death?  pably 4 MUnknot  psy findings availa  mpletion of cause 2 No  HOSPICI
tor: After this certificate has been signed by the attending physician and the funeral director, page 2 should be detached for use as the burial-transit certifier. To Be Completed by Dhymician Addition Exercises	Certification; 10 Be Completed by Physician/Medical Ex	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	b. Due to (or as a consequence of c. Due to (or as a consequence of d. Due	of):  3   Ectopic pregnancy 5   Other (specify)    the underlying cause give  tpatient 3   DOA   Other  ime of 28c. Injury   Word    m, street, factory, office	26. Place of Death /(  3r. 4 □ Nursing Home  vat  ??  Yes 2 □ No  28f	24a. Was an autopsy performed 1 Yes 2 1 Check only one) 5 Residence d. Describe how in City or Town, St.	Month  co use contribute to th	Day Year  ne cause of death?  pably 4 Vunknot  psy findings availa  mpletion of cause 2 No  HOSPICI  I Route Number,
tor: After this certificate has been signed by the attending physician and the funeral director, page 2 should be detached for use as the burial-transit certifier. To Be Completed by Dhymician Addition Exercises	Certification; 10 Be Completed by Physician/Medical Ex	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or as a consequence of Due to (or as a consequence of d.  23c. If yes, outcome of pregnancy 1	of):  3   Ectopic pregnancy 5   Other (specify)    the underlying cause give  tpatient 3   DOA   Other  ime of 28c. Injury   Word    m, street, factory, office	26. Place of Death /(  3r. 4 □ Nursing Home  vat  ??  Yes 2 □ No  28f	24a. Was an autopsy performed 1 Yes 2 1 Check only one) 5 Residence d. Describe how in City or Town, St.	Month  co use contribute to th	Day Year  ne cause of death?  pably 4 Vunknot  psy findings availa  mpletion of cause 2 No  HOSPICI  I Route Number,
tor: After this certificate has been signed by the attending physician and the funeral director, page 2 should be detached for use as the burial-transit certifier. To Be Completed by Dhymician Addition Exercises	ledical Certification; 10 Be Completed by Physician/Medical Ex	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or as a consequence of Due to (or as a consequence of	of):  3   Ectopic pregnancy 5   Other (specify)    the underlying cause give  tpatient 3   DOA   Other  ime of 28c. Injury   Word    m, street, factory, office	26. Place of Death (t)  3r. 4 ☐ Nursing Home  4 at  7?  4 6 2 ☐ No  286  286  286  286  286  286  286  28	24a. Was an autopsy performed 1 Yes 2 1 Check only one) 5 Residence d. Describe how in City or Town, St. d due to the cause at the time, date at	Month  co use contribute to th	Day Year  ne cause of death?  pably 4 Vunknot  psy findings availa  mpletion of cause 2 No  HOSPICI  I Route Number,  ated.  the cause(s)
he Funeral Director: After this certificate has been signed by the attending physician and plately filled in by the funeral director, page 2 should be detached for use as the burial-transit and force of the force	ledical Certification; 10 Be Completed by Physician/Medical Ex	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2  No 9   Unknown  Part II. Other significant conditions  25. Was case referred to medical examiner? 1   Yes 2  No 27. Manner of Death 1  Natural 5   Pending investigation of the determined of the conditions  29a. Certifier (Check only one)	b. Due to (or as a consequence of Due to (or as a consequence of Due to (or as a consequence of Due to (or as a consequence of Due to (or as a consequence of Due to (or as a consequence of Due to (or as a consequence of Due to (or as a consequence of Due to (or as a consequence of Due to (or as a consequence of Due to Due to (or as a consequence of Due to Or as a consequence of Due to (or as a consequence of Due to Or as a	of):  3   Ectopic pregnancy 5   Other (specify)    the underlying cause give  tipatient 3   DOA    time of 28c. Injury Month ime of 28c. Injury Mo	26. Place of Death /(  3r. 4 □ Nursing Home  4 at 286  7 eyes 2 □ No  28f  286  296  297  298  298  298  298  298  298  298	24a. Was an autopsy performed 1 Yes 2 1 Check only one) 5 Residence d. Describe how in City or Town, St. d due to the cause at the time, date at	Month  co use contribute to th	Day Year  ne cause of death' pably 4 Vulknot psy findings availa mpletion of cause 2 No  HOSPICI  I Route Number, ated. the cause(s)
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Medical Certification To Be Completed by Divinional Legisland Completed by Divini	Medical Certification; To Be Completed by Physician/Medical Ex	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or as a consequence of Due to (or as a consequence of	of):  3   Ectopic pregnancy 5   Other (specify)    the underlying cause give  the underlying cause giv	26. Place of Death (t)  3r. 4 ☐ Nursing Home  4 at  7?  4 6 2 ☐ No  286  286  286  286  286  286  286  28	24a. Was an autopsy performed 1 Yes 2 1 Check only one) 5 Residence d. Describe how in City or Town, St. d due to the cause at the time, date at	Month  co use contribute to th	Day Year  ne cause of death' pably 4 Vulknot psy findings availa mpletion of cause 2 No  HOSPICI  I Route Number, ated. the cause(s)
tor: After this certificate has been signed by the attending physician and the funeral director, page 2 should be detached for use as the burial-transit certifier. To Be Completed by Dhymician Addition Exercises	Medical Certification; 10 Be Completed by Physician/Medical Ex	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	b. Due to (or as a consequence of c. Due to (or as a consequence of d. Due	of):  3   Ectopic pregnancy 5   Other (specify)    the underlying cause give  tipatient 3   DOA   Other  ime of 28c. Injury   Word  my of 1    rm, street, factory, office  death occurred at the time of 10 investigation, in my of 10 inves	26. Place of Death /(  3r. 4 □ Nursing Home  4 at 286  7 eyes 2 □ No  28f  286  296  297  298  298  298  298  298  298  298	24a. Was an autopsy performed 1 Yes 2 1 Check only one) 5 Residence d. Describe how in City or Town, St	Month  co use contribute to th	Day Year  ne cause of death bably 4 XUnkno psy findings avail mpletion of cause 2 No  HOSPIC  J Route Number, ated. the cause(s)

DHMH 17 Rev 1/2001

APRIL 24, 2005 12:45 a.m.

JESSIE LOHR

05**-**02778 RKD

Physician	-	I. Decedent's Name (First, Middle, Last	t)					Date of Death Month RIL		_ Year	3. Time of	
/Medical		Merle Willia			1			KIL	20°, 20		5:30P	• '
Examiner	·	a. Facility Name (If not institution, give JOHNS HOPKINS BAY)	VIEW		4b. City, Town, o BALTIMO	RE				nty of Death		
uneral Director		i. Social Security Number  6. Se  176-26-0346  July July Residence of Decedent	7. Age (In	yrs. last birthday) 70 Yrs.	Months Days	Hours	Min.	Date of Birth (Month, Day, t 16	Year) 1934	Cou	place (State o	or Foreig
show dat	1	Oa. State 10b. County	10c	. City, Town or Lo	ocation				<u> </u>		10d. Inside Ci	-
be relified at	-	PA Adams  Oe. Street and Number	8	67 Yor	2 P.d., (	Getty.	sburg	7 Pa 10	173 0g. Citizen o			
236 o		867 York Rd			173					ISA		
r Items 23e	1	Marital Status     Never Married 2  Married	12. Was Decedent Ever i Armed Forces? 1 ☐ Yes 2 X No	in U.S. 13,	Was Decedent of H If Yes, specify Cub	Hispanic Origi an, Mexican,	in? (Specify Puerto Rica	Yes or No- an, etc.)		Race - Amer Black, White		
by Ball		3 ☐ Widowed 4 ② Oivorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 🛣 No	Specify:			Spec	city: (!)h.i.	to.	
tal Hyglene. d other than "natural", event, the Medical Ext Be Completed by		15. Decedent's Edi (Specify only highest grad	ucation de completed)	(Give	dent's Usual Occup kind of work done DO NOT use retired	during most	of working	1	16b. Kind of			
than the Me		Elementary/Secondary (0-12)	College (1-4or 5+)		abled	a)			n	ı/a		
and Mental Hyglene. Is marked other than eumatic event, tha M. To Be Comp		17. Father's Name (First, Middle, Last)		1 023	10200	18. Mother	's Name (F	irst, Middle, N	Maiden Suma	ame)		
arked atic e	2	Robert A. L						Held				
7 Is m treum		19a. Informant's Name/Relationship (T)			ng Address (Street							32
Department of Health and Men Importent; if Item 27 is marke any Injury or other treumatic once.	-	ebra Little  20a. Method of Disposition  1★Burial 2□Cremation 3□1	1	b. Place of Dispo	Granit esition (Name of matory or other plan		LLON Date		20c. Location		4	
rtmen: rtent: njury		* 4 □Donation 5 □ Other (Specify,		hrist!	A Comoto? 2. Name and Addre	ry A	pr 25	5 200!	5 Lit	tles	town	FA
Impo any Ir		21. Signature of Funeral Service Licens	* # 300		eiser Fi			-	1.1		/ 5	
Nedical aminer		Immediate Cause (Final disease or condition resulting in death)	a. Thermal in Due to (or as a con		with comp			spiratory arre			Interval Bet Onset and I	
cian and burial-transit all Examiner		disease or condition	Q	sequence of):	with comp			spiratory and				ween
attending physician and grouse as the burial-transit constant transit constant.		disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate the cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a con	isequence of): isequence of): isequence of): egnancy Fetal death 3	with comp	licati		Spiratory and	23d. D	Date of deliv Month	Onset and I	ween
gned by the attending physician and be detached for use as the burial-transit by Physician/Medical Examiner	F	disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No	Due to (or as a condition of present at time good under the condition of t	isequence of): iseque	□Ectopic pregnanc: □ Other (specify)	licati			23d. D N	Month ontribute to t	onset and I	ween Death
has been signed by the attending physician and ge 2 should be detached for use as the burial-transit ge 2 my physician/Medical Examiner	F	disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate rouse. End thoughing Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1	Due to (or as a condition of present at time good to condition of present at time good to condition of the c	isequence of): iseque	□Ectopic pregnanc: □ Other (specify)	licati		23e. Did tob 1 ☐ Ye  24a. Was ar autopsy perform	23d. D N Pacco use co	Month  ontribute to to   3 □ Pro	onset and I	Year  Year  Jinknor
entificate has been signed by the attending physician and ector, page 2 should be detached for use as the burial-transit be Completed by Physician/Medical Examiner	F	disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate rouse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or as a condition of present at time gold into the contributing to death but not	isequence of): isequence of): isequence of): egnancy Fetal death 3 [ of death 5 [ resulting in the u	□Ectopic pregnanc; □ Other (specify) _  nderlying cause giv	y  y  y  26. Place o	ons	23e. Did tob 1	23d. D N Nacco use co is 2 No 1 1 24b	ontribute to a 3 Prob. Were autoprior to codeath?	rery Day the cause of d bably 4 of t opsy findings. ompletion of c.	Year  Jinkno
his certificate has been signed by the attending physician and indirector, page 2 should be detached for use as the burial-transit.  To Be Completed by Physician/Medical Examiner	F -	disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or as a condition of present the second of the sec	isequence of): iseque	DEctopic pregnance: Other (specify)  Inderlying cause gruent  at 3 DOA of 28c. Injury  at M 1	y  y  y  26. Place of the control of	of Death (C) sing Home	23e. Did tob  1  Ye  24a. Was ar autops; perform 1 Yes 2  heck only one  5  Reside: Describe hor bject re	23d. D No nos 2 No nos 24b nos 6 O w injury occu	Month  ontribute to 1  ontribu	onset and I	Year  Jeath?  Jeath?  Jeath?  Jeath?
bean.  Cur: After this certificate has been signed by the attending physician and the funeral director, page 2 should be detached for use as the buriat-transit cation; To Be Completed by Physician/Medical Examiner	F -	disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or as a cond.  Due to (or as a cond.	isequence of): iseque	Detectopic pregnance Other (specify)  nderlying cause give  a M 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	y y y y y y y en in Part I.	of Death (C sing Home 28d Su fi	23e. Did tob  1  Ye  24a. Was ar autopsy perform 1  Yes 2 heck only one 5  Resider Describe hobject re Location (Str	23d. D  N  Dacco use co  s 2 \( \text{No} \)  1 \( \text{No} \)  1 \( \text{Poly occu} \)  1 \( \text{No} \)  1 \( \text{No} \)  1 \( \text{No} \)  24 \( \text{No} \)  24 \( \text{No} \)  1 \( \text{No} \)  24 \( \text{No} \)  25 \( \text{No} \)  26 \( \text{No} \)  27 \( \text{No} \)  28 \( \text{No} \)  29 \( \text{No} \)  20 \( \text{No} \)  21 \( \text{No} \)  22 \( \text{No} \)  24 \( \text{No} \)  25 \( \text{No} \)  26 \( \text{No} \)  27 \( \text{No} \)  28 \( \text{No} \)  29 \( \text{No} \)  20 \( \text{No} \)  20 \( \text{No} \)  21 \( \text{No} \)  22 \( \text{No} \)  24 \( \text{No} \)  25 \( \text{No} \)  26 \( \text{No} \)  27 \( \text{No} \)  28 \( \text{No} \)  29 \( \text{No} \)  20 \( \text{No} \)  20 \( \text{No} \)  20 \( \text{No} \)  20 \( \text{No} \)  21 \( \text{No} \)  22 \( \text{No} \)  23 \( \text{No} \)  24 \( \text{No} \)  24 \( \text{No} \)  26 \( \text{No} \)  27 \( \text{No} \)  28 \( \text{No} \)  29 \( \text{No} \)  20 \( \text{No} \)  20 \( \text{No} \)  20 \( \text{No} \)  20 \( \text{No} \)  20 \( \text{No} \)  21 \( \text{No} \)  22 \( \text{No} \)  23 \( \text{No} \)  24 \( \text{No} \)  24 \( \text{No} \)  25 \( \text{No} \)  26 \( \text{No} \)  27 \( \text{No} \)  28 \( \text{No} \)  29 \( \text{No} \)  20 \( \text{No} \)  20 \( \text{No} \)  20 \( \text{No} \)  20 \( \text{No} \)  20 \( \text{No} \)  20 \( \text{No} \)  20 \( \text{No} \)  20 \( \text{No} \)  20 \( \text{No} \)  20 \( \text{No} \)  20 \( \text{No} \)  20 \( \text{No} \)  20 \( \text{No} \)  20 \( \text{No} \)  20 \( \text{No} \)  20 \( \text{No} \)  20 \( \text{No} \)  21 \( \text{No} \)  21 \( \text{No} \)  22 \( \text{No} \)  23 \( \text{No} \)  24 \( \text{No} \)  24 \( \text{No} \)  25 \( \text{No} \)  26 \( \text{No} \)  27 \( \text{No} \)  27 \( \text{No} \)  27 \( \text{No} \)  28 \( \text{No} \)  28 \( \text{No} \)  29 \( \text{No} \)  20 \( \text{No} \)  20 \( \text{No} \)  20 \( \text{No} \)  20 \( \text{No} \)  20 \( \text{No} \)  20 \( \text{No} \)  20 \( \text{No} \)  20 \( \text{No} \)	ontribute to 1 3 Pro b. Were autriprior to codeath? 1 Pves  Other (Specieurred ved in the poar or flur heppar)	onset and I  onset	Year  Year  Johnnor  availal ause of
A hours after death.  A hours after death.  Funered Director. After this certificate has been signed by the attending physician and a privated by the funeral director, page 2 should be detached for use as the burial-transit is a likely filled in by the funeral director, page 2 should be detached for use as the burial-transit is a likely filled in by the funeral director. To Be Completed by Physician/Medical Examiner	F	disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or as a cond.  Due to (or as a cond.  Due to (or as a cond.  Due to (or as a cond.  23c. If yes, outcome of present the sum of the sum	isequence of): iseque	Dectopic pregnancy Other (specify)  nderlying cause gruent  a M 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	y  y  y  y  y  y  y  y  y  y  y  y  10  10	of Death (C sing Home 28d Su fi 28f. Nur	23e. Did tob  1  Ye  24a. Was ar autopsy perform 1  Yes 2 heck only one 5  Resider Describe hor bject re Location (Str City or Town, sing House to the ca	23d. D  M  Dacco use co  S 2 \( \text{No} \)  The contract of the contract of	ontribute to 1 3 Pro b. Were autroprior to condeath? 1 Pves  Other (Specieurred ved in the part of Rurher part Gettys)	onset and I  onset	Year John No. availat ause co
A hours after death.  A hours after death.  Funered Director. After this certificate has been signed by the attending physician and a privated by the funeral director, page 2 should be detached for use as the burial-transit is a likely filled in by the funeral director, page 2 should be detached for use as the burial-transit is a likely filled in by the funeral director. To Be Completed by Physician/Medical Examiner	F	disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or as a condition of present the second of the sec	isequence of): iseque	Dectopic pregnancy Other (specify)  nderlying cause gruent  a M 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	y  y  y  y  y  y  y  y  y  y  y  y  y	of Death (C sing Home 28d Su fi 28f. Nur	23e. Did tob  1 Ye  24a. Was ar autops, perform  1 Ye  5 Reside: Describe hor  bject re Location (Str City or Town, Sing H due to the ca	23d. D  M  Dacco use co  S 2 \( \text{No} \)  The contract of the contract of	manner as se, and due to	onset and I  very Day  the cause of d bably 4 Mill opsy findings ampletion of c  2 No  ify)  n wheel fix burg, stated. o the cause(s	Year  John News Area of the Control
or 24 hours after death.  Part and 24 hours after this certificate has been signed by the attending physician and some structure of the struct	F	disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or as a condition of the conditi	sequence of): se	Dother (specify)  Int 3 DOA of 28c. Injury  The a M 1 reet, factory, office Lot  Lot  1 29c. Licens  OCME	26. Place of the part I.  26. Place of the part I.  26. Place of the part I.  26. Place of the part I.  27. All Nurse of the part I.  28. Place of the part I.	of Death (C sing Home 28d Su fi 28f. Nur	23e. Did tob  1  Ye  24a. Was ar autopsy perform 1  Yes 2 heck only one 5  Resider Describe hor bject re Location (Str City or Town, Sing H) due to the ca	23d. D  N  Dacco use co  as 2 No  1 24b  1 24b  2 2 No  2 2 No  1 2 2 No  2 2 No  2 2 No  2 2 No  2 No	ontribute to 1 3 Pro b. Were autorior to codeath? 1 Pos  Other (Special Post of Autority o	onset and I  onset	Year  John News Area of the Control

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** AMPT 1 22ay Donald Edward Magistrelli 2005 10:35 P ัพ /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 110 Sharon Drive Pasadena Anne Arundel 8. Date of Birth (Month, Day, Year) April 15 1 if Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Hours Min 1**X**] M 2□ F Months Yrs. Director 170-30-9192 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits ir than "natural", or Items 23a or 28a-f show The Medical Examiner must be notified at 1 ☐ Yes 2 X No Director Maryland Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21122 USA 110 Sharon Drive filed within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠ Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 🔀 Married Baltimore, Maryland 21215-0036 specify: White 1 Yes 2 No Specify. Ď 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry
Anne Arundel County 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done du life. DO NOT use retired) (Specify only highest grade completed) during most of working I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Public Schools permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygiens Important: if item 27 is marked other tha any injury or other traumatic event, it a gonce. 12 Teacher 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Guido Magistrelli Alice Marie Wortman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 110 Sharon Drive, Pasadena, MD 21122 Anna M. Magistrelli (spouse) 20a. Method of Disposition 20b. Place of Disposition (Name of April 27 20c. Location - City or Town, State cemetery, crematory or other place) 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) Maryland Veterans Cem. 2005 Flintstone, Maryland 21. Signature of Funeral Savice Licensee 22. Name and Address of Facility Stallings Funeral Home, P.A. 31**1**1 Mountain Road, Pasadena, MD 21122 23a. Part1. Enter the disease, or con pli ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only only cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Vastrontestin /Medical Due to (or as a consequence of) Examiner year Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records. P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Year Month Day 4☐ Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown ģ signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? certificate 1 ☐ Yes 2 ☐ No 1 🗌 Yes 2 No Physician: After this certific funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ို 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manger of Death 28d. Describe how injury occurred Certification: Fo the Hospital or Attanding 1 Natural 5 Pending investigation death. 2 Accident 1 ☐ Yes 2 ☐ No Director: the 6 Could not be determined 3 🗌 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28l. Location (Street and Number or Rural Route Number, City or Town, State) in by within 24 hours after To the Funeral Dire 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D0040413 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7010 Ritchie Highway Glen Burnie 21061 Marquerite.
31. Date filed (Month, Day, Year) Summers, State

DHMH 17 Rev 1/2001

Registrar

í			1 - For State Registrar	State of Mar		partment e <i>rtificate</i>			and M	-	giene Reg. No.	)5	14413
	Physici		1. Decedent's Name (First, Middle, Las LESTER V	MCKE	E					2. Date of De.		Year	3. Time of Death 0945 M
	/Medic Examin		4a. Facility Name (If not institution, give	street and number)		4b. City.		Location of			4c. County	of Death	
	Funeral Director	8	220-30-3036	ex 7. Age (	70 Yrs.	y) If Under Months	1 Year Days	If Under	Min.	8. Date of Birt (Month, Da March	v. Year)	Cou	place (State or Foreign ntry) yland
	72 hours after death with the Maryland instural; or Items 23e or 28e-f show disal Examinar must be notified at	rector	Usual Residence of Decedent		oc. City, Town or Severna		Code				10g. Citizen of		1 Od. Inside City Limits 1 Yes 2 No
	th with 23e or	al Di	573 Richard Way				2114	6			USA		
920	s 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hyglene. Item 27 is marked other then "netural", or Items 23e or 28e-f show other treumatic event. I'm Medical Examinating the notified at	by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ev Armed Forces? 1 □ Yes 2√XNo If Yes, Give Year or Dates:	er in U.S. 1	3. Was Deced If Yes, spec		spanic Ori n, Mexican Specify:	gin? (Spe n, Puerto f	cify Yes or No Rican, etc.)	- 14. Rad Bla Specif	ck, White,	can Indian, etc. ite
21215-0036	within 72 ho lene. then "netur the Medical	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)	lucation de completed) College (1-4or 5+)	(Gi	pedent's Usua ve kind of work DO NOT us	k done d e retired	during mosi )		g	16b. Kind of B		
	e filed v al Hygle I other t vent. In	Be Co	17. Father's Name (First, Middle, Last)		Raw	Materi	laı	_		(First, Middle,	Locke Maiden Sumar		lator
ylar	should be nd Mental marked o	To E	Thomas McKee		105 14	Otto - Andrews	(044			Leigh M	liles er, City or Town,	Ct-4- 7:	- 0-4-)
Ma	1 and 2 sho Health and 1em 27 Is ma		19a. Informant's Name/Relationship (			3					c. Maryl		
altimore, Maryland	Pages 1 a nent of Her int: If item iry or othe		20a. Method of Disposition  1  Burial  Cremation 3  4  Donation 5  Other (Specify	Removal from State	20b. Place of Dis	position (Namerematory or of	ne of ther plac	e)	/ D	ate 3-05	20c. Location	City or To	
Balti	permit. Pages Department of Importent: If i any Injury or once.		21. Signatore of Funeral Service Micer	and they	7.		.1y-l	Polyn	iak H	F.H.P.A		1 d	21220
	Physician		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	plications that caused the one cause on each line.	/	enter the mode		g, such as		respiratory and		14110	Approximate Interval Between Onset and Death  VENCS
8760, <	death certificate be executed  e attending physician and idea as the burial-fransit	icai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a c	consequence of):								
O. Box 6		Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown	23c. If yes, outcome of 1 Live birth 2 4 Pregnant at tir	Fetal death	3 □Ectopic pre 5 □ Other (spe						ite of delive	ery Day Year
<u>α</u>	88	by	Part II. Other significant conditions of	- 1/	not resulting in the	underlying ca	ause give	en in Part I.			obacco use con ¶es 2 ☐ No	tribute to t	he cause of death? Dably 4 Unknown
Division of Vital Records,	The law ate has b page 2 sl	Completed								24a. Was autop perfo	rmed?	Were auto prior to co death? 1 \( \sum \text{Yes}	opsy findings available impletion of cause of
Vita	Physicien: The this certificate rat director, pag	Be	25. Was case reterred to medical examiner?	Hospital:			Oth	or.		(Check only o			
on of	Jing After fune	tion: To	1 ☐ Yes 2 ☐ No  27. Manner of Death  ☐ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day )	28b. Time		8c. Injun Worl	4 LI NU	2		dence 6 Oth		(y)
Divisi	E Sign	Sertification:	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc.	/ - At home, farm, (Specify)	street, factory	, office		2	8f. Location (S City or Tov		per or Rura	al Route Number,
	To the Hospitel or within 24 hours after To the Funerel Director completely filled in I	edical C		ysician: To the best of niner: On the basis of e and manner state	xamination and/or								
)	To the To the comp	Ž	29b. Signature and title of centitier	054, M	$\bigcirc$	1	14	number	34	•	APRIL	27	2005
	10		30. Name and address of person who	A MO 3	th (Item 23a) (Typ	PAUL	PLA	rE	BAC	Tron	E, MO	212	01
	Sta Regist		31. Date filed (Month, Day, Year)  APR 2 8 200	5 2. Registrar	s Signature.	Me de							

		14	1 - State Registrer	State of Maryland	•	ertment of I		nd Mental Hy	giene	
	Physici	an	1. Decedent's Name (First, Middle, Last)	B. Maciejews				2. Date of D Month April		3. Time of Death 12:15p <sup>M</sup>
	/Medic Examin		4a. Facility Name (If not institution, give str		JK I		ville	Death	4c. County of De	eath
	Funeral Director		042-09-1032	7. Age (In yrs. last 86	t birthday) Yrs.	If Under 1 Year Months Days		Min. 8. Date of Bi (Month, D June 2	o, 1918 C	lirthplace (State or Foreign Country) Onn
	Maryland -f show	tor	Usual Residence of Decedent  10a. State 10b. County  MD Baltimo:	re Pa	Town or Locarkvi					10d. Inside City Limits 1 ☐ Yes 2 No
	h with the	ai Direc	10e. Street and Number 9660 Magledt Ro	oad		10f. Zip Code 2123	4		10g. Citizen of What	Country?
980	be filed within 72 hours after death with the Maryland tal Hygiene.  do other than "netural", or itams 23a or 28a-f show event, the Madical Examinar must be notified at	by Funeral Director	11. Marital Status 12 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	. Was Decedent Ever in U.S. Armed Forces? 1 _Yes 2 _Xho If Yes, Give Year or Dates:	li li	Vas Decedent of Yes, specify Cub	an, Mexican,	n? (Specify Yes or N Puerto Rican, etc.)	o- 14. Race - Ar Black, WI Specify Wh	
Maryland 21215-0036	within 72 ho ene. then "netur	Completed	15. Decedent's Educa (Specify only highest grade		(Give l	ent's Usual Occu kind of work done OO NOT use retire	i during most o ed)	of working	Hair Dre	ss/Industry
land 2	should be filed and Mental Hygid marked other umatic event, II	To Be Co	12th 17. Father's Name (First, Middle, Last) Kondart Baran				18. Mother	s Name (First, Middle alie Masl		
Mary	nd 2 should be the and Mental 27 is marked traumatic ev		19a. Informant's Name/Relationship (Type Walleen Lewis /					or Rural Route Numb	ner, City or Town, State	, Zip Code)
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Importent: if Item 27 is marked any Injury or other traumatic ev		20a. Method of Disposition  1  Burial 2  Cremation 3  Rei  4  Donation 5  Other (Specify)	20b. Place	e of Dispos etery, crem	sition (Name of satory or other pla	ice)	Date 5/3/05	20c. Location - City Norwich	
Balti	permit. Departr importe any inju		21. Signature of Funeral Service License	Tonnelle	1	Name and Address 300 Ma	ce Ave	a Baltin	noro MD 2	
	Physician /Medical		23a. Part1. Enter the disease, or complica shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)	CANCER	- 2.	to MACK	ng, such as ca	ardiac or respiratory a	rrest,	Approximate Interval Between Onset and Death
J	Examiner	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease on hijbry that initiated events resulting in death) Last	Due to (or as a consequen	nce of):					
68760,	death certificate be executed e ettending physician and od for use as the burial-transit	dicai	d.	Due to (or as a consequen	ice of):		176-1873			
О. Вох	를 다 나 다 나	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 mooths? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	c. If yes, outcome of pregnancy 1 Live birth 2 Fetal de 4 Pregnant at time of death 9 Unknown	ath 3 🗌	Ectopic pregnand Other (specify)	у		23d. Date of d Month	elivery Day Year
<u>α</u>	sign d be	þ	Part II. Other significant conditions contr	ibuting to death but not resultin	ng in the un	derlying cause gr	ven in Part I.	- 1	tobacco use contribute Yes 2 PNo 3 I	to the cause of death?  Probably 4 Unknown
Division of Vital Records,	The law ate has t page 2 s	Completed						24a. Was auto perfe 1 \( \text{Yes}	ormed2 death:	autopsy findings available o completion of cause of es 2 2 No
Vita	Physicien: Th this certificate ral director, pag	To Be	25. Was case referred to saminer?  1 Yes 2 100	spital: 1 ☐ Inpatient 2 ☐ ER	/Outpatient	3□ DOA Ott	200	f Death (Check only	one) dence 6 □Other (Sp	ecify)
ion of	To the Hospitel or Attending Phys within 24 hours after death. To the Funerel Director: After this completely filled in by the funeral director.		27. Mann Death  1 Natural 5 Pending investigation		b. Time of Injury	28c. inju Wo	ry at	28d. Describe	how injury occurred	- 7,
Divis	itel or Att rs after de rel Direct led in by t	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At home building, etc. (Specify)	, farm, stre	et, factory, office		28f. Location ( City or To	Street and Number or i wn, State)	Rural Route Number,
	To the Hospitel c	edicai		cien: To the best of my knowle r: On the basis of examination and manner stated.						
)	To t To t	Σ	29b. Signature and title of certifier	>		D /		MANLANCE	29d. Date signed (Mo)	
	10		30. Name and address of person who com	pleted cause of death (Item 23 PAS MD 5	3a) (Type, F	Print)	u Rd	Cockass	4/26/ ville Md	2/030
	Sta Registr		31. Date filed (Month PR 2 8 20	20 Diffringenda Cionatura	Z A	well.				

			Pleas	e Type or Prir							•
			1 - For State Registrar	State of Ma	aryland / l	Departmen <i>Certificat</i>			and Mental Hy	/giene 0 0 5	14415
			Registrar  1. Decedent's Name (First, Middle,	l ast)		Certificat	e or L	Jean	2. Date of D	Reg. No.	10 T- (D-4
ı	Physic		DONALD	ORESTON	MA	RSCH	ILE		Month	Day Year	3. Time of Death
	/Medi Examir		4a. Facility Name (If not institution,					Location o	f Death	4c. County of De	3   7. 33 F
			FOREST HA	VEN NUR	SING H	OME C	ATO	NSI	ILLE	1	MORE
	Funeral		5. Social Security Number		e (In yrs. last bir	thday) If Under Months	1 Year Days	If Under 2 Hours	24 Hrs. 8. Date of B Min. (Month, D	rth 9. B	irthplace (State or Foreign
y.	Director		Usual Residence of Decedent		80	Yrs.			Jan.22		wYork
	yland now		10a. State 10b. County		10c. City, Tow	n or Location					10d. Inside City Limits
	Mar a-f st	tor	MD Balt	imore	Ro	sedale					1 ☐ Yes 2 No
	or 28	Director	10e. Street and Number			10f. Zip	Code			10g. Citizen of What C	Country?
	ath w		9713 Philade			2	123	7		USA	
	within 72 hours after death with the Maryland ene. then "natural", or Iteme 23s or 28s-f show (a Medical Exal are mast be notified at	Funeral	11. Marital Status	12. Was Decedent 8 Armed Forces?		13. Was Deced	dent of His offy Cubar	spanic Orig n, Mexican,	in? (Specify Yes or N Puerto Rican, etc.)	14. Race - Am Black, Wh	
36	irs aft	by F	M☐ Never Married 2☐ Marrie 3☐ Widowed 4☐ Divorced	d XXYes 2 1 N If Yes, Give Year or Dates:	10	1 ☐ Yes	2 <b>X</b> No	Specify:		Specify: W]	hite
21215-0036	2 hou	ted	15. Decedent's	Education	16a.	Decedent's Usua	al Occupa	tion		16b. Kind of Busines	s/Industry
218	thin 7	Completed	(Specify only highest Elementary/Secondary (0-12)	grade completed)  Coltege (1-4or 5	+)	(Give kind of wor life. DO NOT us	rk done di se retired)	uring most	of working	Chesapea	
2	filed with Hygiene. other than	Con	11th	-		Crane O	pera	ator		Dreging	
gue	be fill d oth	Be	17. Father's Name (First, Middle, La Henry Marsch	•					's Name (First, Middle	, Maiden Sumame)	
Maryland	should be ind Mental i marked o umatic eve	2	19a. Informant's Name/Relationship		405	A 4 10	/2:		/ Lassen		
Ma	0 0 = 0		Donald Marsc							er, City or Town, State, sville MD	
ē,	s 1 and 2 I Health Item 27 other tre		20a. Method of Disposition		20b. Place of	Disposition (Nam	ne of	1	Date Dyke	20c. Location - City o	
Baltimore,	Pages nent of t ant: If its ury or of		1 ☐ Burial 2 ☐ Cremation 3 1 ☐ Donation 5 ☐ Other (Spe		Bayvi	y, crematory or of .ewCrem	ther place. ator	) Y	4/23/05	Baltimore	
alti	permit. Pag Department Important: I any injury c		21. Signature of Funeral Service Li		00	22. Name and	d Address	of Facility			
<u>m</u>	88 5 8		K. Terr	4 Conn	elle	30	0 Ma	ace A	Ave. Balt	imore MD	meofEssex
			23a. Part 1. Enter the disease, or co shock, or heart failure. List or	polications that caused in one cause on each line		ot enter the mode	e of dying,	, such as c	ardiac or respiratory a	rrest,	Approximate Interval Between
	Physician		tmmediate Cause (Final disease or condition	a	CER	EBRA	1	1+	HOMBO	SIS	Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a	consequence	of):					
<sup>20</sup> . 3	Maria A	16	Sequentially list conditions, if any, leading to immediate	b	consequence	<b>6</b>					
T	nsit	nine	Cause (Disease or injury	Due to (or as a	consequence	и;:					
Α,	te be executed ysician and e burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to (or as a	consequence	of):					
$\sim$	te be ysicia ie bur			d							
9	death certificate I e attending physi id for use as the t	Physician/Medical	IF FEMALE:								
Вох	ath ce ttendi	an/I	23b. Was decedent pregnant in the past 12 months?	23c. tf yes, outcome of 1 ☐ Live birth 2	of pregnancy P Fetal death	3 □Ectopic pre	gnancy			23d. Date of de	
		/sici	1 Yes 2 No	4□Pregnant at t 9□Unknown	ime of death	5 Cother (spe				Month	Day Year
۵.	The law requires that the de tte has been signed by the a vage 2 should be detached to	Phy	Part II. Other significant conditions	contributing to death but	t not resulting in	the underlying on	use awar	in Part I	22a Did	obacco use contribute to	a the server of describe
ds,	w requires that been signed is should be det	d by			a not rooditing in	the chostlying ca	use given	iliranı.		res 2 □ No 3 □ Pi	
00	been shou	ete				<del></del>			-		
Re	The lav	Completed							24a. Was autor perfo		atopsy findings available completion of cause of
		0	25. Was case referred to medical					26 Place o		2€ No 1 Yes	20 No
₹	d is	To B	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 tnpatien	t 2 ER/Out	patient 3 DOA	Other			tence 6 Other (Spe	cihu)
Division of	ding Ph h. After th funeral		27. Manner of Death Natural 5 Pending	28a. Date of Injury (Month, Day			lc. Injury a Work?			now injury occurred	cny)
Sio	Attendil death. ctor: A y the fu	catle	2 ☐ Accident investigat	ion		M		s 2 No			
Ž	or Atten after deat Director: in by the	Certification;	3 Suicide 6 Could not 4 Homicide determine	d 28e. Place of trijur building, etc.	y - At home, fare (Specify)	m, street, factory,	office		28f. Location (S City or Tox	Street and Number or Ru m, State)	ıral Route Number,
	To the Hospitel or Ai within 24 hours after or To the Funeral Directompletely filled in by		29a. Certifier	Physician: To the best of	mu ka auda d						
	Hos 24 hc Fun etely	Medical	(Check only 2 Medicat Ex.	Physician: To the best of sminer: On the basis of and manner state	skaimination and	death occurred a for investigation, i	t the time, in my opin	, date and nion, death	place, and due to the occurred at the time,	cause(s) and manner as date and place, and due	stated. to the cause(s)
	Nithin Fo the Complex	Me	29b. Signature and title of certifier	ſ		29c.	License r	number		29d. Date signed (Monti	h, Day, Year)
			Jasnoeu	n Hall	lan		7 9	1859	5	4/22/0	3
			30. Name and address of person wh	completed cause of dea		Type, Print)	0			1	
	Ų		TASNEEM	LAKHAN	1, 7.	220 1	MAR	k t	tel CAHTS	AVE, SA	HERO MI)
	Star Registra		31. Date filed (Month, Day, Year)	32. Registrar	's Signature	- 51					24200
DH	H 17 Rev 1/20		APR 2 8 20	05 Stewn	N 6						
ארוט	17 NeV 1/20	N I		,	ORIO	GINAL					

			1 - For State Registrar	State of Ma	aryland / Depa	artment <i>rtificate</i>			id Me		giene Reg. No.	005	14416
	Physic /Medi		1. Decedent's Name (First, Middle, La Mary Ellen Moon	st)						2. Date of De Month April	Day	Year 005	3. Time of Death 2:30 A M
	Exami	_	4a. Facility Name (If not institution, given 1023 E1m Rd.	e street and number)		4b. City, To		ocation of D			4c. Co	ounty of Death	
	Funeral Director		5. Social Security Number 6. S 192-14-2337	Sex 7. Ag I□M 2【ATF	e (In yrs. last birthday) 81 yrs.	If Under 1		if Under 24 Hours	Min.	B. Date of Bird (Month, Da May 5,	th y, Year)	9. Birth	nplace (State or Foreign untry) nnsylvania
	Maryland -1 show	tor	Usual Residence of Decedent  10a. State 10b. County  Maryland Baltim	nore	10c. City, Town or Lo						1		10d. Inside City Limits 1 □ Yes 2 🛣 No
	death with the Maryland ms 23e or 28a-f show r roust be multiked at	al Director	10e. Street and Number 1023 Elm Rd.			10f. Zip C 212						n of What Cou	untry?
920	or Ite	by Funeral	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces? 1  Yes 2  If Yes, Give Year or Dates:	10	Was Deceder If Yes, specify		panic Origin Mexican, P	? (Spec uerto Ri	ify Yes or No- can, etc.)		Race - Amer Black, White Decify: White	, etc.
Maryland 21215-0036	be filed within 72 hours Ital Hygiene. Id other then "netural", event, I're Medical Ere	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)	ducation ade completed) College (1-4or 5	(Give	dent's Usual ( kind of work DO NOT use demaker	done dui retired)	on ring most of	working	,	16b. Kind	of Business/Ir	,
yland	12 should be filed within h and Mental Hygiene. 7 Is marked other then "reumetic event, the Mex	To Be (	17. Father's Name (First, Middle, Last, Anthony Reddick					Lotti	e Re		(mai	den unk	
	ges 1 and 2 should it of Health and Men if item 27 is marke or other treumetic		19a. Informant's Name/Relationship ( William Moon, so	** .	1820	Palo	Cir.			Route Numbe	or, City or To	own, State, Zi 27	p Code)
Baltimore,	permit. Pages 1 and 2 Department of Health a Importent: If item 27 Is any injury or other tre once.	800	20a. Method of Disposition  12 Burial 2 □ Cremation 3 □  4 □ Donation 5 □ Other (Specif.		20b. Place of Dispo cemetery, cren Cedar Hil	natory or other	er place)	04	Dai -29-			tion - City or T Klyn Pa	own, State ark, MD
Ball	permit. Pa Departmen Importent: any injury		21. Signature of Funeral Service Licer	72	1	328 Su	1phu	ır Spr	ing	e, Inc.	Arbuti	ıs, MD	21227
ł	Physician /Medical Examiner		23a. Part1. Enter the disease, or comshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a	the death. Do not entered to a consequence of):	er the mode of	of dying,	such as car	diac or r	espiratory an	rest,	4	Approximate Interval Between Onset and Death
8760,	icate be executed physician and the burial-transit	dlcal Examiner	Sequentially list conditions, if any, leading to immediate cause. Either Underlying Cause (Disease or injury that initiated events resulting in death) Last	C	a consequence of): a consequence of):								
O. Box 6	The law requires that the death certificate be executed tte has been signed by the attending physician and tage 2 should be detached for use as the burial-transit	Physiclan/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	23c. If yes, outcome of the control	2 ☐ Fetal death 3 ☐	Ectopic pregi Other (speci					23d	. Date of delive	ery Day Year
rds, P.	quires that en signed b	by	Part II. Other significant conditions o	ontributing to death bu	it not resulting in the ur	iderlying caus	se given	in Part I.			bacco use es 2∯ZN		he cause of death?
Il Records,	: The law requicate has been page 2 should	Completed				-			_	24a. Was a autops perform	an 2 sy med? 22No	4b. Were auto prior to co death? 1 \(\sum Yes\)	ppsy findings available impletion of cause of 2 2 No
ion of Vital	or Attending Physician: The siter death. Director: After this certificate him by the funeral director, page	ation; To Be	25. Was case referred to medical examiner?  1  Yes 2 No  27. Manner of Death  1 Natural 5 Pending investigation	Hospital: 1 ☐ Inpatier  28a. Date of Injun (Month, Day			Other: Injury at Work?	4 ☐ Nursin	g Home	Check only or 5/22 Reside	ence 6 🗆	Other (Specif	iy)
Division	tal or Attences after death	Certification;	3 Suicide 6 Could not be determined	28e. Place of Inju building, etc.	ry - At home, farm, stre . (Specify)	eet, factory, of	ffice		28f	. Location (Si City or Town	treet and No n, State)	um <i>ber</i> o <i>r Rur</i> a	al Route Number,
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	ledical	one)	ysician: To the best o liner: On the basis of and manner stat	f my knowledge, death examination and/or inv ted.	occurred at t estigation, in	he time, my opini	date and pla ion, death o	ace, and	I due to the cat the time, d	ause(s) and late and pla	d manner as si ce, and due to	tated. the cause(s)
•	To t Com	M	29b. Signature and title of certifier	White	M.D.		cense ni			2	9d. Date si	gned (Month,	
	10		atrick w	white	ath (Item 23a) (Type, F	1310	to	mo	l		٧		
••	Sta Registr		31. Date filed (Month, Day, Year)  APR 28 20		r's Signature	ales .							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 5 For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** BARBARA Α. MASON /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** NIA narylano General If Under 1 Year If Under 24 Hrs. a Date of Birth (Month, Day, Year)

Months Days Hours Min. 05 01 1947 Birthplace (State or Foreign Country)

MD 7. Age (In yrs. ocial Security Number 6. Sex **Funeral** Months 212-48-0218 57 Director Usual Residence of Decedent 10d Inside City Limits 10c. City, Town or Location 10a. State 10b County 28a-f show ust be notified at 1 Yes 2 No BALTIMORE Director MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number VANCOUVER ROAD 21229 4732 238 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status The Medical Examiner: 1 □ Never Married 2 □ Married Specify: BLACK 1 ☐ Yes 2 1 No Specify Maryland 21215-0036 þ 3 NWidowed 4 □ Divorced natural 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) SOCIAL WORKER STATE MD 12/14 GRADE other t 18. Mother's Name (First, Middle, Maiden Surname) Ith and Mental Hve 7 is mark-17. Father's Name (First, Middle, Last) MARIE BLUE WELLS PHILLIP 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) ST. BALTO MD 21223 Pages 1 and 2 ment of Health a snt: If item 27 Is 3 N. BENTALOU BRIAN MASON 20c. Location - City or Town, State Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ♣ Burial 2 ☐ Cremation 3 ☐ Removal from State injury or 05.02.05 BALTO, MD permit. Page Department of Important: If any injury or once. ARBUTUS \* 4 ☐ Donation 5 ☐ Other (Specify) VAUGHN C. GREENE FUNERAL SERVICE 21. Signature of Funeral Service Licensee 5151 BALTO. NATE PIKE, BALTO. MD 21229 an Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory shock, or heart values. List only one cause on each line. Acute Cardiac ARREST Immediate Cause (Final disease or condition resulting in death) Anoxic Encelphalopathy **Physician** /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 5 ☐ Other (specify) P.O. 9 Hinknown The law requires that the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Records. teriphera 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy 1 ☐ Yes 2 ☐ No Division of Vital or Attending Physician: 26. Place of Death (Check only one) 25. Was case referred to medical examiner?

1 Yes 2 No Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) NZInpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Bate of Injury (Month, Day Year) 27. Manger of Death 28b. Time of 28d. Describe how injury occurred Director: After 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide within 24 hours a To the Funeral C completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medicai 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier tranier,

State Registrar 31. Date filed (Month, Day, Year) 32. Resistrar's

se of death (Item 23a) (Type, Print)

N. J. Y. NARYAN GENERAL HOSPI

Reflector's Signature

David Andrew Mocko 05-02860 d.

1				it in Black In					•
		1 - For Unpend Item 23 Registrar	State of Ma a,27,28a	f per me	artment of F C843 5-24 Tillicate of	Tealth and Death as	Mental Hyg	plene 005	1418
Physic	cian	Decedent's Name (First, Middle, Last)					2. Date of Dea Month	Day Yee	
/Med		David Andrew Moc  4a. Fecility Name (If not institution, give so			4h City Town o	or Location of Dea		4, 2005 4c. County of De	3:10 P M
Exam	iner	501 Sussex Road	reel and number,		Towson	COCATION OF DOA	411	Baltimon	
Funera	1	5. Social Security Number 6. Sex		(In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs			lirthplace (State or Foreign Country)
Directo	r	222-44-135/	<sup>M 2□F</sup> 46	Yrs.	Worldis	riours Will	April 5	, 1959	PA
land ow		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Limits
Mary a-f sh	tor	MD Anne Arun	del	Hanover					1 ☐ Yes 2 🔀 No
th the or 28s	Oirec	10e. Street and Number		1,01,000	10f. Zip Code		1	log. Citizen of What	Country?
ath wi	rai	6948 Ridge Road			21076			USA	
ING 21215-U036  be filed within 72 hours after death with the Maryland tal Hygiene. Id other than "naturel", or Items 23a or 28a-f show event. I're Medical Frantier matte notified at	by Funeral Director	11. Marital Status  1 Never Married 2 🕅 Married  3 Widowed 4 Divorced	<ol> <li>Was Decedent I Armed Forces?</li> <li>1 ☐ Yes 2 ☐ N</li> <li>If Yes, Give Year or Dates:</li> </ol>	lo	Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 🕱 No	Hispanic Origin? (! an, Mexican, Puel Specify:	Specify Yes or No- rto Rican, etc.)	14. Race - Ar Black, WI Specify: W	
5-0 72 ho	Completed	15. Decedent's Educ (Specify only highest grade	ation completed)	(Give	dent's Usual Occup	during most of we	orkina I	16b. Kind of Busines	ss/Industry
within ne.	mpidu	Elementary/Secondary (0-12)	College (1-4or 5	+) life.	DO NOT use retire	d) "	9		stallation
d 21 filed wit Hygien other the	ပိ	12 17. Father's Name (First, Middle, Last)		10	oilermake		me (First, Middle,	and Repa	iir
arylano should be ind Mental is marked o	To Be	George Paul Moc	ko			Elizab	eth Dav	vidson	
M 2 Ith	ľ	19a. Informant's Name/Relationship (Type Susan Mocko/wife	e, Print)				lura/Route Number	r, City or Town, State 21076	, Zip Code)
Baltimore, Dermit Pages 1 ar Department of Hea Important: If item: any injury or other	1	20a. Method of Disposition	Chata	20b. Place of Dispo	osition (Name of matory or other plan	ce)	Date	20c. Location - City of	or Town, State
Page ment and and and and and and and and and and		1 ☐ Burial 2 ☒ Cremation 3 ☐ Re  '4 ☐ Donation 5 ☐ Other (Specify)	moval from State	Hilltop S	Svc. Corp	04/2	27/2005	Towson, M	1D.
Ball sermit Separt mport nny in	THE STATE OF THE S	21. Signature of Funeral Service License	。 epberi Cos						Home, Inc.
		23a. Part1. E ter the disease, or complic					owson, Ma		1204 Approximate
Physiciar		shock, or heart failure. List only one Immediate Cause (Final	e cause on each lin	θ.		ig, saon as cardio	to or respiratory and	<b>Ф3</b> (,	Interval Between Onset and Death
/Medica	1	disease or condition resulting in death)		cam Intoxical consequence of):	cation				
Examine		Sequentially list conditions.							
be sit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Causa (clistase or hijery	Due to (or as	a consequence of):					
60, be executed sicien and burial-transit	Examin	that initiated events resulting in death) Last	Due to (or as	a consequence of);					
760 e be e sicien	caiE	d							
Box 687 death certificate e attending physical for use as the	fedio							-	
Box sath cert attendin for use	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	ic. If yes, outcome 1 Live birth		Ectopic pregnancy	v		23d. Date of d	,
	ysici	1 Yes 2 No	4□Pregnant at 9□ Unknown	time of death 5	Other (specify)			Month	Day Year
2 2 B		Part II. Other significant conditions conf	ributing to death be	at not resulting in the u	nderlying cause giv	ren in Part I.	23e. Did tol	bacco use contribute	to the cause of death?
ecords, law requires t as been signe	ed by						1 □ Ye	es 2, <b>⊠(</b> No 3⊡!	Probably 4 Unknown
ecord law require as been si 2 should to	Completed						24a. Was a	n 24b. Were	autopsy findings available
	Com						autops perforr 1X Yes	med? death? 2 □ No 2 □ No	
Vital R siclan: The certificate h rector, page	Be	25. Was case referred to medical examiner?	onitale		0.1		ath (Check only on	(e)	
Phys r this c ral dir	1°	1 X Yes 2 No	ospital: 1 ☐ Inpatie 28a. Date of Injur			4 Nursing I		ence 6 X Other (Sp ow injury occurred	pecify) SCENE
On rding th. : After	tion	1 □Natural 5 □ Pending 2 □ Accident investigation	(Month, Da) 4-24-05	Year) Found:	f 28c. Injur Wor P M 1 □	rk? Yes 2. <b>X</b> No		ingested	drug
Division  or Attanding after death. Director: Afte	ertification:	3 Suicide 6 ☐ Could not be determined		ry - At home, farm, sti . (Specify)	_	A	28f Location (St	reet and Number or I	Rural Route Number
Ditel or its after rel Dir	O		Found: 1	rivate dwe	elling			Saltimore	
Division of Vital  To the Hospitel or Attending Physician: within 24 hours after death.  To the Funerel Director: After this certifics completely filled in by the funeral director,	edical	29a. Certifier 1 Certifying Physical Check only one) 2 Medical Examin	cian: To the best of er: On the basis of and manner sta	of my knowledge, deat. examination and/or in ted.	h occurred at the tir vestigation, in my o	me, date and plac pinion, death occ	e, and due to the ca urred at the time, d	ause(s) and manner a ate and place, and di	as stated. ue to the cause(s)
To th within To th	Me	29b. Signature and life of certifier	MAN		29c. Licens	e number	2	9d. Date signed (Mor	nth, Day, Year)
1		Mar	XVV		OCME		A	pril 25, 2	2005
(10)	Special Control of the Control of th	30. Name and address of person who cor	noleted cause of de	eath (Item 23a) (Type,		G1 :			
	tate	31. Date filed (Month, Day, Year)	32. Registra	r's Signature	III Penn	Street,	Baltimon	re, Maryla	and 21201
Regis		APR 2 8 200	a	K A	and a				

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State of Maryland / Department of Health and Mental Hygiene 1- State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Mc Cullough **Physician** AORI/ 3:45 PM KAthaRine 2005 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner N. Streeper Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 1 □ M 2 🕏 F 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Months MARY Land 215-74-8607 Yrs. Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside Çity Limits 28a-f show other traumatic event, the Medical Examiner must be nutified at 1 Pres 2 □ No Bolt more Director Md 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 9 532 Streeper 21205 USA or Items 23a 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 No Specify: þ 3 Widowed 4 Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. 90 NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Domostic fomemaker 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be SR. Bish Mildred Lewis M. Koch 19a. Informant's Name/Relationship (Type, Print) Husband 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21205 532 N. Streeper permit. Pages 1 and 2 Department of Health a Importent: If Item 27 is any injury or other trat <u>once.</u> Konahd McCullough Balto. Md. Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)

OAKLawn Cemetery 20c. Location - City or Town, State 20a. Method of Disposition 1 🖪 Burial 2√□ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Spenify) 21. Signature Finera Service Licensee Batto. Md. retropolyan Chare 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Cardiac Arrhythmia disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Unsease or injury that initiated events Due to (or as a consequence of) burial-transit certificate be executed Exam resulting in death) Last Due to (or as a consequence of): Box 68760, attending physician lan/Medical the as IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ō in the past 12 months? Day Year 4□Pregnant at time of death signed by the at d be detached for 5 Other (specify) P.0. 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 Yes 2 No 3 Probably 4 Minknown should I Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 XYes 2 □ No autopsy performed? 1 Yes 2 🔲 No Division of Vital within 24 hours after death.

To the Funerel Director: After this certific completely filled in by the funeral director, Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 X ther (Specify) 5CERE ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) OCME Apri 15, 2005 Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar Locke ATD

32. Regil rar's Signature

J. Laron Loc

31. Date filed (Month, Day Year)

III Pennst.

Balto MD ZIZOI

					Plea	ise 1	Гуре or Pri	nt in	Black	Indeli	ble Ink.	Ensure A	I Copies	s Are	e Legi	ble.	
			1 - For	ite gistrer			State of M	laryla			ent of H ate of L	ealth and M Death	lental Hy	gien	~ ~	m pa	
	Physic		1. Dece	dent's Name	e (First, Midd	le, Last	MILDF	RED A	RBUTU				2. Date of Do Month	eath D	ay	Year co5	3 Time of beath U
	/Medi Exami				f not institution		street and number				City, Town, or	Location of Death	71711	26	c. County	of Death	
	Funeral		5. Socia	Security N	umber	6. Se		ge (In yrs	. last birtho	day) If Ur	der 1 Year	If Under 24 Hrs. Hours Min.	8. Date of Bi (Month, Da	ay, Yea	N/		nplace (State or Foreign intry)
	Director			-26-7 esidence of				81	ity. Town o				Feb 13	, 19	924		t Virginia
	with the Maryland a or 28a-f show	Director		land	Anne		undel		.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		Bal	timore					10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	ath with the Marylan 23a or 28a-1 show		10e. Str	eet and Nur		Har	mmonds La	ne		10f.	Zip Code	21225		10g. C	itizen of V USA	Vhat Cou	ntry?
့်	0 2 E	Funeral		tal Status Never Marri	ed 2□ Mar		12. Was Decedent Armed Forces 1  Yes 2	?	J.S.	If Yes,	specity Cubai	spanic Origin? (Spon, Mexican, Puerto	ecify Yes or No Rican, etc.)	0+		e - Amer k, White	ican Indian, , etc.
5-003	"neturel", or Item	ted by	3 🗆		4 Divorced	nt's Edu	Year or Dates:		16a. De	ecedent's l	s 2 No	Specify:		16b.	Specify Kind of Bu		White
Maryland 21215-0036	l within iene. r than *	Completed	Eleme		ity only highen ndary (0-12)	st grad	College (1-4or	5+)	(G lif	Bive kind of fe. DO NO	work done d Tuse retired) Omemak	uring most of work	ng				Mother
and 2	be file ital Hyg id othe event,	Be	17. Fath	er's Name (	First, Middle,		Stalnake			- 11		18. Mother's Name		, Maide	n Sumam	ne)	110 61761
lary	s 1 and 2 should be f f Health and Mental P item 27 is marked of other traumatic eve	To			me/Relations	hip (Ty	pe, Print)		19b. M	lailing Addr	ess (Street a	Esther nd Number or Rure	Ston I Route Numb				code)
	ges 1 and 2 of Health If item 27 is		20a. Me	thod of Disp			Daughter	20b. i	Place of Di	isposition /	ibs La Name of or other place	ne, Balti	more,	Md. 20c. l	212 ocation -	19 City or T	own, State
Baltimore,	nit. Pagartment ortant: injury o						lemoval from State	Вау	/view	Crema	atory,	Inc. 4/2					Maryland
Ba	Depa Impo eny it			7	1		cations that cause			McCu 237	lly-Po Pat	lyniak Fu apsco Ave	neral Bal	Home time	e, P. Ore,	A. Md.	21225-1856
	Pnysician		Immedia	ate Cause (I or condition	tialiure. Lisi Final	only or	ne cause on each i	ine.					· ·		14/2		Approximate Interval Between Onset and Death
	/Medical Examiner		Ì	in death)	***		Due to (or as	a consec	quence of):	-UCT	ive P	Respira	× 0.	See al S	9		
V	cuted nd ransit	aminer	Cause (	tially list con lading to im Enter Under Disease or i lated events	njury	₹	Due to (or as	a consec	quence of):			- 1,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	1	,0,,			
68760,	be exe ician a burial-t	Щ.		in death) L		°	Due to (or as	a conseq	quence of):								
x 687	certificate iding phys se as the	Medic	IF FEMA	ALE:													
.O. Box	that the death certifice led by the attending ph detached for use as ti	Physician/Medical	in t 1 □	s decedent he past 12 r Yes 2 2 Unknown	months?	2	3c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Fete	el death	3 □Ectopio 5 □ Other	pregnancy (specify)				23d. Date Mon		ary Day Year
rds, P	ires sign d be	by	Part II, O	ther signifi	cant condition	ons con	tributing to death b	out not res	sulting in the	e underlyin	g cause giver	n in Part I.	23e. Did to				he cause of death?
I Records,	The law ate has be page 2 sh	Completed	_												Di di		psy findings available mpletion of cause of
Vital	sicien: certific rector,	Be	exam	case referra	ed to medica	_	ospital:				Other	26. Place of Death	(Check only o	ne)			
of	ding h. After fune	tlon: To	27. Manr 1 🖼	ner of Death latural Accident		g	28a. Date of Inju (Month, Da		ER/Outpat 28b. Time Injury	e of	28c. Injury	at 2	ne 5 ☐ Resid 8d. Describe h				()
Division	al or Attending s after death. Il Director: After id in by the fune	Certification:	3 🗀 :	Suicide Homicide	6 Could determine	not be	28e. Place of Inj building, et	ury - At ho c. (Specif	ome, farm,				8f. Location (S City or Tox	Street ar vn, State	nd Numbe e)	r or Rura	i Route Number,
	To the Hospital or At within 24 hours after of To the Funerel Directompletely filled in by	Medical C	29a. Cer (Ch	oun orny	1 - Certifyin 2 - Medicel	g Phys Ex <b>am</b> in	ician: To the best er: On the basis o and manner st	r examına	wledge, de	eath occurre investigati	ed at the time on, in my opi	, date and place, a nion, death occurre	nd due to the d d at the time, d	cause(s date an	) and man d place, a	ner as si	ated. the cause(s)
	To the l within 2 To the l complet	Me	29b. Sign	nature and t	itle of certifie		,			2	29c. License	number		29d. Da	te signed	(Month,	Day, Year)

State Registrar

Churles Crittina
31. Date filed (Month, Day, Year)
APR 2 8 2005 DHMH 17 Rev 1/2001

3

00

32 Registrar's Signature

0.0

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number Res-000

SINA HOSPITAL OF BAIT, MOVE

			1 - For State Registrar	Sta	ate of Mar	yland / Depa <i>Ce</i>	artment of rtificate of	Health <i>Death</i>	and Me		giené Reg. No.	m m m m	14421
	Physic	on	1. Decedent's Name (First, Mid							2. Date of Dea	ath Day	/ Year	3. Time of Death
	/Medi		Elmer Edward l	Nash, J	r.				A	pril	27,	2005	5:55 AM
	Examir	ner	4a. Facility Name (If not institut	-			4b. City, Town,	or Location	of Death		4c.	County of Death	
			Joseph Richey	Hospic	e		Balti	more					
	Funeral		5. Social Security Number	6. Sex		In yrs. last birthday)	If Under 1 Year Months Days		r 24 Hrs.	B. Date of Birt (Month, Da	th V Year)	9. Birth	place (State or Foreign
	Director		220-64-3058	1 (2) M 2	5.	l Yrs.		710010	.VIII.	2-23-1	954		yland
	pus *		Usual Residence of Decedent  10a. State 10b. Coun	tv	1	Oc. City, Town or Lo	anting.						
	lary!	2	MD	•,	1	Baltimore	Cation						10d. Inside City Limits 11 Yes 2 □ No
	ith the Marylan or 28a-f ahow	ect	100 Street and Number				T						
	72 hours after death with the Maryland natural', or Items 23a or 28a-f ahow Jirgal Examirast be notified at	Funeral Director	10e. Street and Number 2629 Georgeton	vn Rd.			10f. Zip Code 21230					zen of What Cou U.S.A.	ntry?
	death ms 2	era	11. Marital Status		as Decedent Ev		Was Decedent of	Hispanic Or	igin? (Spec	ify Yes or No-		14. Race - Ameri	can Indian
မွှ	after or Ite	Ē	1 Never Married 2 M	arned 1	med Forces? □Yes 2 🛣 No		If Yes, specify Cut	ban, Mexica	n, Puerto Ri	ican, etc.)		Black, White,	
8	rali, c	by	3 ☐ Widowed 4 反 Divorce	ed If Ye	res, Give ar or Dates:		1 ☐ Yes 2 ☑ No	Specify.	:			Specify: Wh:	ite
21215-0036	72 honatu	Completed	15. Decede (Specify only high	ent's Education	nleted)	16a. Dece	dent's Usual Occu kind of work done	pation	at at wanting		16b. Kir	nd of Business/Ir	dustry
2	ithin ie.	nple	Elementary/Secondary (0-12		llege (1-4or 5+)	life.	DO NOT use retire	ed)	SE OF WORKING	<b>'</b>			
2	filed within Hygiene. othar than " ant, the Wes	S	7			Freig	ght	,			War	ehouse	
nd	be fill tal H d oth	Be	17. Father's Name (First, Middle					18. Moth	er's Name (	First, Middle,	Maiden	Sumame)	
yla	2 should be f and Mental I la marked of aumatic ava	2	Elmer Edward I							ay Sch			
Maryland	5 = 7 = 1	1	19a. Informant's Name/Relation John Brock, Bi		ntj	196. Mailir 2961	ng Address <i>(Str</i> ee Mauview	Rd. B	eror <i>Rum</i> all alitm	Route Numbe ore MD	r, City or 212	Town, State, Zi <sub>l</sub> 30	Code)
ē,	s 1 au of Hea itam otha		20a. Method of Disposition			20b. Place of Dispo	sition (Name of natory or other pla	200)	Dat	te	20c. Lo	cation - City or To	own, State
altimore,	Page nent c ant: If ury or		1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other		al from State	Bayview (			4-28-	05	Balt	imore, N	Œ
Balt	permit. Pages 1 Department of H Important: If ita any injury or ot		21. Signature of Funeral Service	e Licensee		An I	Name and Addr hbrose Fi 328 Sulph	ess of Facili ineral lur Sp	Home ring	Rd <sup>Inc</sup>	butu	s MD 212	227
			23a. Part1. Enter the disease, shock, or heart failure. Li	or complications	s that caused the	e death. Do not ent	er the mode of dy	ing, such as	cardiac or r	respiratory arr	rest,		Approximate
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a	Hepat Due to (or as a c	obiliar	y Carci	nom	a	-			Interval Between Onset and Death
	Examiner				20 10 (01 40 4 0	oneoqueneo ory.							
	₽ ≅	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Ь. —	ue to (or as a c	onsequence or):							
	ficate be executed physician and is the burial-transit	Examiner	that initiated events	c									
ó,	e exe ian a urial-		resulting in death) Last		Due to (or as a c	onsequence of):							
68760,	ate b hysic he bi	edical		d									
		Med	IF FEMALE:			-							
Вох	death certifii e attending I id for use as	an/l	23b. Was decedent pregnant in the past 12 months?		es, outcome of p Live birth 2 [		Ectopic pregnanc	v			2	3d. Date of delive	•
0	0 0 0	Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 E 9 E	Pregnant at tim Unknown	e of death 5□	Other (specify)					Month	Day Year
σ.	that the de led by the a		Part II. Other significant condi	tions contributing	ng to death but n	ot resulting in the ur	nderlying cause on	ven in Part I		23e. Did tol	bacco us	se contribute to th	ne cause of death?
of Vital Records,	law requires that the as been signed by th 2 should be detache	ed by									es 2 □		_
00	law reas bee	olete								24a. Was a	ın İ	24b Were auto	psy findings available
æ	0 - 0	Completed								autops perforr	med?	prior to cor death?	npletion of cause of
ta	ician: Th certificate rector, pag	a	25. Was case referred to medic	al				26 Place	of Death //	1 □ Yes 2 Check only on	2 No	1 🗆 Yes	No
>	Phyaician: this certificatal director,	.o.	examiner? 1 ☐ Yes 2 No	Hospital	1  Inpatient	2 ER/Outpatient	t 3□ DOA Ott	205		5 Reside		Other (Specific	Hospica -
	g Ph er th	T:U	27. Manner of Death		Date of Injury (Month, Day Ye	28b. Time of	28c. Injui			d. Describe ho		-	TRAICE
Ö	Attanding in death. actor: After by the funer	atlo	1. Natural 5 ☐ Pend 2 ☐ Accident inves	ing tigation	(Month, Day re	ea <i>r)</i> Injury		rk? ∣Yes 2 🗀 l	No				
Division	l or Attano after death Diractor: in by the	ific	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide deter	I not be mined 28e.	Place of Injury	At home, farm, stre	eet, factory, office		28f	Location (St	reet and	Number or Rura	l Route Number,
Ö	tal or A rs after al Dira ed in by	Certification:	Tomordo		building, etc. (5	ор <del>о</del> спу)				City or Towr	n, State)		
	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the funer	edical	29a. Certifier 1 Cartify (Check only one) 2 Madica	Laammer: On	To the best of m the basis of exi d manner stated	ny knowledge, death amination and/or inv	occurred at the tire estigation, in my o	me, date and opinion, deat	d place, and th occurred	due to the ca at the time, da	ause(s) a ate and p	ind manner as st place, and due to	ated. the cause(s)
	To th Withir To th comp	Me	29b. Signature and title of certifi	er			29c. Licens	e number		2	9d. Date	signed (Month, I	Day, Year)
	d		> 55TW 1	M			D	2417	70	Λ	Loril	27, 200	5
Ż	`		30. Name and address of person						· · ·		•		
			31 Date filed (Month Day Year	chey Ho	A Designation	01	utaw ST	Ba	Himor	e Mi	21	201	
*	Sta Registr	te ar	31. Date filed (Month, Day, Yea, APR 2 8	2005	Lave .	Signature Some	W	_					

EDWARD NASH

	1	For Stata Registrar		of Maryland		rtificate of			Reg. I	711113	5 144
nysician		. Decedent's Name (First, Middle						2. Date of		Day Yea	3. Time of De
Medical		KI	NAM					Apr	1  2	4, 2005	08:32
xaminer	4.	a. Facility Name (If not institution	•				or Location of [	Death		4c. County of De	
	5	Greater Baltin	6. Sex	7. Age (In yrs. la		Towson If Under 1 Yea	r   If Under 24	Hrs. 8 Date of		Baltimo	re Sirthplace (State or F
neral ector		214-84-6657	11 M 2□F	66	Yrs.	Months Days		Hrs. 8. Date of Month	30°, 19	38 Sau	Country Tun Korea
		Isual Residence of Decedent									
notified at		0a. State 10b. County		10c. City	, Town or Lo						10d. Inside City
octo			timore		Lock	eysville	?				1 Tes 2
	,	0e. Street and Number 14 Sugar Tree	D1000			10f. Zip Code 21 03	n			Citizen of What	•
instrant by natified Funeral Director	-	1. Marital Status		edent Ever in U.S	13 1			? (Specify Yes o		outh Ko	rea nerican Indian,
F	.   '	1 ☐ Never Married 2 🔀 Marri	Armed F			f Yes, specify Cu	ban, Mexican, F	uerto Rican, etc.	)	Black, W	
b S		3 Widowed 4 Divorced	If Yes, G Year or I	ive		1 ☐ Yes 2 💢 No	Specify:			Specify:	Jhite
the Medical Examiner must be Completed by Funeral Di		15. Decedent (Specify only highes	's Education		16a. Deced	dent's Usual Occi	upation	f working	16b.	Kind of Busines	ss/Industry
		Elementary/Secondary (0-12)	T	(1-4or 5+)		kind of work done DO NOT use retir		Working		·	
ent, the M		7. Father's Name (First, Middle, I	/ noti			f employ		Name (First Att			al Cleanir
ever Be	5	Kun Woo	Nam					Name (First, Mid	idie, Maide Hee	Shin	
raumatic ever		19a. Informant's Name/Relationsh			19h Mailir	ng Address (Stree		or Rural Route Nu			Zin Codo)
Trans.		Mr. Tae Nam – 9						ce, Cock	-		
any injury or other traumatic event, the Monce.  To Be Comp	-	Oa. Method of Disposition		20b. Pl	ace of Dispo	sition (Name of		Date		Location - City	
5		1 ☑ Burial 2 ☐ Cremation  4 ☐ Donation 5 ☐ Other (Sp				natory or other pl Ley Mem'l.		/30/05	Ti	monium, M	D
in id	2	21. Signature of Funeral Service t		iam G. Dau		-		Ruck Tows			
any ic	1	Mulas						son, MD 2			,
ourial-transit e	o t t	Sequentially list conditions, any, leading to immediate ause. Enter Underlying Cause (Disease or injury hat initiated events esulting in death) Last	c	(or as a consequ							
Physician/Medical Examir	1 2	F FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 Live	utcome of pregnar birth 2  Fetal nant at time of de	death 3	Ectopic pregnant	су			23d. Date of d Month	elivery Day Yea
5 I 2	-	Part II. Other significant condition	ns contributing to a	leath but not resu	Iting in the u	nderhving cauco g	won in Part I	230 [	id tobacco	a use contribute	to the cause of deat
P deta	2	1000									Probably 4 Dunk
be be								1	□ 162	_	, –
be be	-					<u> </u>		-	<del>-</del>	24h Word	autopou findingo que
pe 2 should be o	-							24a. V	Vas an utopsy enformed?	prior to	autopsy findings ava
page 2 should be c	-	25. Was case reterred to medical					OC Place of	24a. V a p 1 □ Ye	Vas an utopsy enformed?	prior to	completion of caus
director, page 2 should be o		25. Was case referred to medical examiner? 1 □ Yes 2 ☑ No	Hospital:	Inpatient 2 I F	-R/Outpatien	t 30 DOA 0		24a. V a p 1 Ye	Vas an utopsy enformed?	prior to death?	completion of caus
director, page 2 should be of To Be Completed by		examiner? 1 ☐ Yes 2 ☑ No 7. Manner of Death	28a. Date		ER/Outpatien 28b. Time of	t 3⊡ DOA O	ther: 4 🗆 Nursii	24a. V a p 1   Ye Death Check or	vas an utopsy erformed? es 2 DA	prior to death?	completion of caus
neral director, page 2 should be on To Be Completed by		examiner? 1   Yes 2   No  7. Manner of Death 1   Natural 5   Pending 2   Accident investig	28a. Date (Mor			28c. Inju	ther: 4 🗆 Nursii	24a. V a p 1   Ye Death Check or	vas an utopsy erformed? es 2 DA	prior to death?  lo 1 Ye  6 Other (Sp	completion of caus
neral director, page 2 should be on To Be Completed by		examiner? 1 □ Yes 2 ☑ No  7. Manner of Death 1 ☑ Natural 5 □ Pending	28a. Date (Mor		28b. Time of Injury	28c. Inje We M 1	ther: 4 Nursii ury at ork? Yes 2 No	24a. V a p 1   Ye Death Check or ng Home 5   R 28d. Descri	Vas an utopsy erformed? es 2 2 1 1 one esidence be how in	prior to death 1 Ye	completion of caus
neral director, page 2 should be on To Be Completed by	2	examiner?  1 Yes 2 No  7. Manner of Death  1 Matural 5 Pending  2 Accident investig  3 Suicide 6 Could n  4 Homicide  29a. Certifier 1 Certifyin	28a. Date (Mornator be need 28e. Place build	of Injury oth, Day Year) e of Injury - At hor ling, etc. (Specify,	28b. Time of Injury	28c. Inju Wi M 1 [	ther: 4 Nursii ury at ork? Yes 2 No	24a. V a p 1  Ye Death Check or ng Home 5  R 28d. Descri	Vas an utopsy enformed? s 2 D ne desidence be how in the cause of the	for the death of the last of t	completion of causes 2 No
neral director, page 2 should be on To Be Completed by	2	examiner?  1	28a. Date (Mornation lot be ned 28e. Place build g Physician: To the Examiner: On the and mar	of Injury nth, Day Year)  e of Injury - At hor ling, etc. (Specify, e best of my know pasis of examinationer stated.	28b. Time of Injury  ne, farm, stri  vledge, death on and/or inv	28c. Ini W M 1 [ eet, factory, office n occurred at the top stigation, in my 29c. Licer	ther: 4 Nursing At ork? Yes 2 No	24a. V a p 1   Ye Death Check or ng Home 5   R 28d. Descri  28f. Locatic City or	As an utopsy enformed? s 2 DA one esidence be how in Town, Statiche cause (ne, date a 29d. D	for the death of t	exampletion of causes  as 2 No  exercity)  Rural Route Number  as stated.  ue to the cause(s)
Certification; To Be Completed by	2	examiner?  1	28a. Date (Mornation lot be ned 28e. Place build g Physician: To the Examiner: On the and mar	of Injury nth, Day Year)  e of Injury - At hor ling, etc. (Specify, e best of my know pasis of examinationer stated.	28b. Time of Injury  ne, farm, stri  vledge, death on and/or inv	28c. Ini W M 1 [ eet, factory, office n occurred at the top stigation, in my 29c. Licer	ther: 4 Nursing At ork? Yes 2 No	24a. V a p 1   Ye Death Check or ng Home 5   R 28d. Descri  28f. Locatic City or	As an utopsy enformed? s 2 DA one esidence be how in Town, Statiche cause (ne, date a 29d. D	for the death of t	exampletion of causes  as 2 No  exercity)  Rural Route Number  as stated.  ue to the cause(s)
neral director, page 2 should be on To Be Completed by	2	examiner?  1	28a. Date (Mornation lot be ned 28e. Place build g Physician: To the Examiner: On the and mar	of Injury nth, Day Year)  e of Injury - At hor ling, etc. (Specify, e best of my know pasis of examinationer stated.	28b. Time of Injury  ne, farm, stri  vledge, death on and/or inv	28c. Ini W M 1 [ eet, factory, office n occurred at the top stigation, in my 29c. Licer	ther: 4 Nursing At ork? Yes 2 No	24a. V a p 1   Ye Death Check or ng Home 5   R 28d. Descri  28f. Locatic City or	As an utopsy enformed? s 2 DA one esidence be how in Town, Statiche cause (ne, date a 29d. D	for the death of t	exampletion of causes  as 2 No  exercity)  Rural Route Number  as stated.  ue to the cause(s)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Item/Ioa, per FH, 6842, 5/28/05 II
State of Maryland / Department of Health and Mental Hygiene 1 - For Stete Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Month **Physician** Year FLORENCE NE WMAN 24 April /Medical 2001 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner HOSPITAZ RANDALLSTON N BALTIMORE NURTHWEST If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 07/07/1921 6 Sax 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 X F 067-14-8670 83 Yrs. Director N.Y. Usual Residence of Decedent the Maryland 10a State 10c. City, Town or Location 10d. Inside City Limits 10h County Worle "netural", or items 23e or 28a-f ehov idical Examiner must be notified at MD BALTIMORE RANDALLSTOWN Director 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with 1 nent of Heatth and Mental Hyglene. Int: If item 27 is marked other than "netural", or Items 23e or 2 4011 ROUEN ROAD 21133 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify: Specify: WHITE þ 3 X Widowed 4 ☐ Divorced th and Mental Hygiene.
77 Is marked other than "netur traumatic event, the Medical. 16a. Decedent's Usual Occupation (Give kind of work done during most of working Res 16 NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry grade completed) (Specify only highest Compl College (1-4or 5+) Elementary/Secondary (0-12) RESIDENCE BUYER GARMENT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be **JOSEPH** STEIN JENNIE LIPSCHIT7 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other train ance. DANA SHUMARD / DAUGHTER 4011 ROUEN ROAD RANDALLSTOWN, MD 21133 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State HILLTOP SERVICE CORP. 04/27/2005 TOWSON, MD ` 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licensee whit 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) days prieumonia /Medical Due to (1 r as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (15-35) or july that initiated events resulting in death) Last Due to (or as a consequence of): Examiner sician and burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): inding physician a use as the burial-Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant atter for u 1 ☐ Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. I 1 ☐ Yes 2€ No 9 ☐ Unknown 9 Unknown signed b I be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 2000 1 ☐ Yes 1 🗆 Yes Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 1 ☐ Yes 3€ No 1 Propatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) After th funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification; 28d. Describe how injury occurred 1 Datural 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation hours after deat 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) à 4 Homicide Vithin 24 hours after To the Funeral Dir Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number MD DOOS 9736 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DEBORAH NULTH WEST MD HUSPITAL 0-0 COURT RUMO 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

**ORIGINAL** 

2885	State of Maryland / Department of Hest State Unpend Item 23a&27 per me G843 5-5-05 tas Certificate of Department of Hest State Unpend Item 23a&27 per me G843 5-5-05 tas Certificate of Department of Hest State Unpend Item 23a&27 per me G843 5-5-05 tas Certificate of Department of Hest State Unpend Item 23a&27 per me G843 5-5-05 tas Certificate of Department of Hest State Unpend Item 23a&27 per me G843 5-5-05 tas Certificate of Department of Hest State Unpend Item 23a&27 per me G843 5-5-05 tas Certificate of Department of Hest State Unpend Item 23a&27 per me G843 5-5-05 tas Certificate of Department of Hest State Unpend Item 23a&27 per me G843 5-5-05 tas Certificate of Department of Hest State Unpend Item 23a&27 per me G843 5-5-05 tas Certificate of Department of Hest State Unpend Item 23a&27 per me G843 5-5-05 tas Certificate of Department of Hest State Unpend Item 23a&27 per me G843 5-5-05 tas Certificate of Department of Hest State Unpend Item 23a&27 per me G843 5-5-05 tas Certificate of Department of Hest State Unpend Item 23a&27 per me G843 5-5-05 tas Certificate of Department of Hest State Unpend Item 23a&27 per me G843 5-5-05 tas Certificate of Department of Hest State Unpend Item 23a&27 per me G843 5-5-05 tas Certificate Of Department of Hest State Unpend Item 23a&27 per me G843 5-5-05 tas Certificate Of Department of Hest State Unpend Item 23a&27 per me G843 5-5-05 tas Certificate Of Department of Hest State Unpend Item 23a&27 per me G843 5-05 tas Certificate Of Department of Hest State Unpend Item 23a&27 per me G843 5-05 tas Certificate Of Department Of Hest State Unpend Item 23a&27 per me G843 5-05 tas Certificate Of Department Of Hest State Unpend Item 23a&27 per me G843 5-05 tas Certificate Of Department Of Hest State Unpend Item 23a&27 per me G843 5-05 tas Certificate Of Department Of Hest State Unpend Item 23a&27 per me G843 5-05 tas Certificate Of Department Of Hest State Unpend Item 23a&27 per me G843 5-05 tas Certificate Of Department Of Hest State Unpend Item 23a&27 per me G843 5-05 tas Certifi	alth and Mental Hygiene eath Reg. No. 2 1 1 5 1 1 1 2 1
Dhysisian	Decedent's Name (First, Middle, Last)	2. Date of Death  Month  Day  Year  3. Time of Death
Physician /Medical	ALLEN A. PARSONS	APRIL 25, 2005   1934 P M
Examiner	4a. Facility Name (If not institution, give street and number)  NORTH ARUNDEL HOSPITAL  GLEN BURN	
Funeral Director		Hours Min. Solution (State or Foreign Month, Day, Year)  Jan. 30,1974  9. Birthplace (State or Foreign Country)  Maryland
aryland ahow	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits 1 □ Yes 2 ✓ No
or 28a-f ahow e rutified at	Maryland Anne Arundel Linthicum	
uter death with the Mauter death with the Mauter as 38 or 28s-1 and refer must be notified.	10e. Street and Number         10f. Zip Code           308 Silky Oak Court         21090	O U.S.A.
Baltimore, Maryland 21215-0036  permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If then 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Evandral must be notified at once.  To Be Completed by Funeral Director	Armed Forces? If Yes, specify Cuban,	anic Origin? (Specify Yes or No- Mexican, Puerto Rican, etc.)  14. Race - American Indian, Black, White, etc.  Specify: White
Maryland 21215-0036 td 2 should be filed within 72 hours aft this and Mental Hygiene. 27 is marked other than "natural", or rearmatic event, the Medical Exert To Be Compileted by F	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)	on ing most of working 16b. Kind of Business/Industry
led will her th her th nt. the	12 0 Marine Mechani	
yland build be fill Mental H marked out attic even	17. Father's Name (First, Middle, Last) Denny Wayne Parsons	8. Mother's Name <i>(First, Middle, Maiden Sumame)</i> Carolyn Ida Skierkowski
lary and h and h	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and	d Number or Rural Route Number, City or Town, State, Zip Code)
e, M	Carolyn I. Parsons (Mother) 308 Silky Oak  20a. Method of Disposition (Name of	Court, Linthicum, Maryland 21090  Date 20c. Location - City or Town, State
Baltimore, permit. Pages 1 ar Department of Heal mportant: If Item into injury or othe ance.	1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State  '4 ☐ Donation 5 ☐ Other (Specify)  Ceday: Hill Cem.	04-29-05 Brooklyn Park, Maryland
Balt permit. Depart Import any inje	21. Signature of Funerart Service Licenses  22. Name and Address of McCully-Poly 3204 Mountain	of Facility yniak Funeral Home P.A. in Road, Pasadena, Marvland 21122
	233 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause of each line.	
Physician / /Medical	Atherosclerotic Cardiovascul resulting in death)  Atherosclerotic Cardiovascul Due to (or as a consequence of):	
Examiner		
sit ed	Sequentially list conditions, if any, leading to immediate cause. List of Joseph Cause (Disease or injury	
68760, icate be executed physician and s the burial-transit	resulting in death) Last  C	
	d	
vision of Vital Records, P.O. Box 6 Attending Phyaician: The law requires that the death certifi death. sotor: After this certificate has been signed by the attending, by the funeral director, page 2 should be detached for use as fification: To Be Completed by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify)	23d. Date of delivery  Month Day Year
rds, P.O. I quires that the de- n signed by the a uld be detached f	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in	in Part I. 23e. Did tobacco use contribute to the cause of death?  1  Yes 2 No 3 Probably 4 Unknown
Division of Vital Records, of or Attending Physician: The law requires the after death.  Director: After this certificate has been signed in by the funeral director, page 2 should be certification: To Be Completed by		24a. Was an autopsy findings available prior to completion of cause of death?  1 \( \) Yes 2 \( \) No
Vital F ician: Th certificate rector, pag	eyaminer?	6. Place of Death (Check only one)
on of Vital Re- ding Phyaician: The land. After this certificate has funeral director, page 2 tion: To Be Comp	27. Manner of Death 1 X Natural 5 □ Pending 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work?	4 Nursing Home 5 Residence 6 Other (Specify)  t 28d. Describe how injury occurred  s 2 No
in partie	2 Accident (investigation 3 Suicide 4 Domicide determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)
the Hospital thin 24 hours is the Funeral I empletely filled	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, 2X Medical Examiner: On the basis of examination and/or investigation, in my opini and manner stated.	
To the within 2 To the complet	29b. Signature and title of certifier 29c. License no	umber 29d. Date signed (Month, Day, Year)
	) him ki, m. ) OCME	APRIL 26, 2005
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	
C1-1-	31. Date filed (Month, Dav. Year) 32. Remistrar's Signature	enn Street Baltimore, Maryland 21201
State Registrar	APR 2 8 2005	

			1 - For State Registrar	State of Maryland		rtment			ind M		Reg. No.	200	5	ententie .	25
	Physici		1. Decedent's Name (First, Middle, Las Agnes, Procte							2. Date of De Month	Day		ear	3. Time of 0.3/3	
	/Medio Examin		4a. Facility Name (If not institution, give		-	4b. City, T		ocation o		Fpril	- 1	County of			
	Funeral Director		5. Social Security Number 6. Social Security Number 1			If Under 1 Months	Year Days	If Under 2 Hours	Min	8. Date of Bir (Month, Da 12 - 18 - 10	V Year	9	. Birthpl Count	ace (State or	r Foreign
	how		Usual Residence of Decedent  10a. State 10b. County	10c. City, T									10	d. Inside Cit	•
	the Ma	Director	MD NJF	BALTI	More	10f. Zip (	Code				10a Citi	izen of Wha	-1 Court	1 <b>(X</b> Yes	2 No
	Mith with			IVENUE			1215				rog. Oil	US		ıy:	
920	be filed within 72 hours after death with the Maryland ital Hyglene. id other than "natural", or itams 23a or 28e-f show green! The Medical Examinational be notified at sevent, the Medical Examinational be notified at	by Funeral	11. Marital Status  1 Never Married 2015 Married  3 Wildowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 0 No If Yes, Give Year or Dates:	If	Vas Decede Yes, speci	fy Cuban	panic Orig , Mexican Specify:	gin? (Spe , Puerto I	cify Yes or No Rican, etc.)	)-	14. Race - Black, Specify:	White, e	etc.	
21215-0036	within 72 ho ene. than "natur the Medical I	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)	ucation 1 de completed)  College (1-4or 5+)  N/A	(Give i	lent's Usual kind of work OO NOT use	done du	ion uring most	of workin	ng	16b. Ki	ind of Busin		ustry	
Maryland 2	should be filed with ind Mental Hygiene. s marked other that umatic svent, The I	To Be Co	17. Father's Name (First, Middle, Last) DAVID ROSS, SR.	· γ <sub>β</sub>	01110			18. Mother		(First, Middle,	, Maiden	Surname)			
Mar	d 2 shi th and th and traum		19a. Informant's Name/Relationship (7) MOSES PROCTOR	**	19b. Mailin 3509				r or Rura VE .	BALTO			ate, Zip		
Baltimore,	Pages 1 and 2 nent of Health int: If Item 27 iry or other tra		20a. Method of Disposition 1 ⊞Burial 2 □ Cremation 3 □	Removal from State	e of Dispos etery, crem	sition (Name natory or oth	e of	) [	D	ate	20c. Lo	ocation - Cit	ty or Tov	vn, State	
altim			<ul><li>4 □ Donation 5 □ Other (Specify</li><li>21. Signature of Funers) Service Licen</li></ul>				Address			3.2005 JERAL 8			NOTE	in. u	D
ä	permit. Departr Importa any inji		Naugh_ (	4	516	JGHN (	70 · N	IATC F	IKE,	BALTO	· MD	2122	9		.=. ,,
	Physician /Medical Examiner		23a. Part1. Enter the disease, or compositions and the composition of the composition resulting in death)	a. Due to (or as a consequen				, such as o	cardiac o	r respiratory a	rrest,			Approximate Interval Betw Onset and D	veen
8760,	554	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (of as a consequen  c. Due to (or as a consequen  d.	,										
P.O. Box 68	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal de 4 □ Pregnant at time of death 9 □ Unknown	ath 3	Ectopic pre Other (spe						23d. Date o Month			ear
	uires that n signed k ld be det	by	Part II. Other significant conditions of	ontributing to death but not resulting	-		use giver	n in Part I.			obacco u Yes 2		ute to the	e cause of de	eath?
al Records,		Completed								24a. Was autor perfo		prio dea		sy findings a pletion of ca 2 \( \text{No} \)	
Vital	Physicien: Th this certificete ral director, pag	o Be	25. Was case referred to medical examiner?	Hospital:	·O					(Check only o		. 57.0			
of	arth. r: After this		1 Yes 2 No  27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year) 28	Outpatient b. Time of Injury		lc. Injury	at	2	ne 5 Residente l	dence (	y occurred	(Specity)	)	
Division	To the Hospitel or Attending within 24 hours after death.  To the Funerel Director: After completely filled in by the funer	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At home building, etc. (Specify)	, farm, stre	et, factory,	office		2	8f. Location ( City or Tou	Street an wn, State	d Number (	or Rural	Route Numb	oer,
	To the Hospitel or within 24 hours afte To the Funerel Dir completely filled in	Medical	29a. Certifier 1 Certifying Ph (Check only one) 2 Medicel Exam	ysicien: To the best of my knowle liner: On the basis of examination and manner stated.	dge, death and/or inv	occurred a estigation, i	t the time in my opi	e, date and nion, deat	d place, a h occurre	nd due to the ed at the time,	cause(s) date and	and manne d place, and	er as sta d due to	ited. the cause(s)	
	To the To the Complex	Me	29b. Signature and the of certifier	D.O.			License				-	te signed (A			_
,			30. Name and address of person who	completed cause of death /Item 23	Ba) (Type, I	Print)	152				MP		1	2003	
	4		Susan Lee D.O.	32. Registrar's Signature	st, E	BaHim	iore,	MI	) 2,	1001					
	Sta Registi		31. Date filed (Month, Day, Year)  ADD 9 Q	32. Registrar's Signature	H I	hart.									

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** PRESTON APRIL 9:43 AM LEROY. 26 2005 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Bon Secours Hospital Baltimore If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 12 M 2□F Yrs. Director 217-03-9979 04/05/1917 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits th and Mental Hygiene.
71's marked other then "natural", or Items 23a or 28a-f show treumait event, the Medical Examinations to ricitive a 1 Yes 2 □ No **Funeral Director** Maryland <u>Baltimore</u> 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Importent: If Item 27 is marked other then "--- any injury or other treumes". 501 W. Franklin Street 21201 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No þ 3 ☐ Widowed 4 ☐ Pivorced Specify: Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 8 Farmer Farming 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Ernest Howard Preston Bertha Sidney Jarrett 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1045 Lakefront Dr., Edgewood, Maryland Charles H. Peaker / 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Zion Cemetery 04/30/2005 Landsdowne, Maryland 21. Signature of Funeral Service License 22. Name and Address of FacilityThe Derrick C. Jones F/H, P.A. 4611 Park Hgts. Ave., Baltimore, Maryland 21215 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final Fnysician disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of P.O. Box 68760, the attending physician hed for use as the burial Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 99 1 Yes 2 No 3 Probably Unknown Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 2 2 No 1 ☐ Yes To the Hospitel or Attending Physicien: 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 1 Yes 2 No 2 ER/Outpatient 3 DOA this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred after death. I Director: After to 28b. Time of Certification; Natural 2 Accident 5 Pending 1 Yes 2 No investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funerel D 11 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie M.D. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) S. S. DANG M(, D., 10) 11. Date filed (Month, Day, Year) ST. HELENA BALTIMORE State APR 2 8 2005 Registrar

			1 - For State Registrar	State of Man		rtment of F		and Mental	Hygier	2005	14427
	Physicia		1. Decedent's Name (First, Middle, Last)  ARTHUR H.	PEUGH				2. Date of Month	1 [	27 2005	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give st North Grundel			4b. City, Town, o	Location	of Death		Anne A	
	Funeral Director		5. Social Security Number 6. Sex		n yrs. last birthday) 83 Yrs.	If Under 1 Year Months Days	If Under Hours	24 Hrs.   a Date	of Birth Day 19	O Dies	nplace (State or Foreign untry)
	yland 10w		Usual Residence of Decedent  10a. State 10b. County	10	Oc. City, Town or Loc	cation					10d. Inside City Limits
	the Mar 28a-f sl	ector	Maryland   Anne Arui	ndel	Hanov	er			100	Citizen of What Co	1 ☐ Yes 2 📆No
	23a or	al Dir	7424 Hawkins Drive			210	76		109.	USA	unay:
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If Item 27 is marked other than "natural, or Items 23a or 28a-f show any highry or other traumatic event, I'm M. d'eal Examiner must be notified at once.	by Funeral Director	11. Marital Status 1  1 X Never Married 2 Married 3 Widowed 4 Divorced	Was Decedent Eventh Armed Forces?     Was 2 □ No If Yes, Give Year or Dates:	1941	Vas Decedent of F i Yes, specify Cuba □ Yes 2∑ No	ispanic Ori in, Mexican Specify:	gin? (Specify Yes i, Puerto Rican, etc	or No-	14. Race - Amer Black, White Specify: Wh	e, etc.
21215-0036	vithin 72 horne. ne. hen "naturi e M. offall I	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	ation completed) College (1-4or 5+)	(Give	lent's Usual Occup kind of work done OO NOT use retired	during mos	t of working		Kind of Business/	ŕ
1d 2;	e filed v Il Hygie other t vent, II	Be Co	17. Father's Name (First, Middle, Last)			arpenter	18. Mothe	or's Name (First, M			11
Maryland	should be filed vand Mental Hygies smarked other tumatic event, III	To B	Yraul Peugh	Corion)	405 14.75	111		ucille	UKN		
	alth and 2 st		19a. Informant's Name/Relationship (Type Mary Smith, Stepdan			_				y o <i>r Town, S</i> tate, Z <b>, Maryl</b> an	
ore	iges 1 and of the information of the		20a. Method of Disposition 1 □ Burial 2 ☑ Cremation 3 □ Re	moval from State	-	natory or other plan		Date		Location - City or 1	
altimore,	permit. Pa Departmer Importent any Injury once.		'4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service License		Metro Cre		,	04/27/05 oty 05 M		,	Maryland
<u>a</u>	99 = 5		Thomas Gregor	eations that caused th	e death. Do not ente	199 Frede	rick	Road Bal	imor	nd Inc. e, Maryla	nd 21228 Approximate
	Physician /Medical	e q	23a. Part1. Enter the disease, or complice shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)	Aspira	tion Pn	eumonia		oardiae or respirat	, arroot,		Interval Between Onset and Death
	Examiner		Sequentially list conditions, b.	Due to (or as a c	isia						( week
,00	icate be executed physician and s the buriat-transit	l Examiner	if any, leading to immediate cause. Enter undertying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a c	evascular	accide	<del>*</del>				2 weeks
P.O. Box 68760,	ath certif ttending or use as	Physiclan/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of 1 ☐ Live birth 2 { 4 ☐ Pregnant at tim 9 ☐ Unknown	Fetal death 3	Ectopic pregnance	,			23d. Date of deli Month	very Day Year
	quires that the de n signed by the a uld be detached f	by	Part II. Other significant conditions conditions	. j Chronic	ch struction	e lung	en in Part I	. 23e.	Did tobacc		the cause of death?
I Records,	The ate h page	Completed	conjustive houst	Feilure,	hyperte	Msion!			Was an autopsy performed 'es 2 M	prior to death?	topsy findings available ompletion of cause of 2 \sum No
Vita	scertific irector,	Be	25. Was case referred to medical examiner?	ospital:	2 ER/Outpatien	t 3□ DOA Ott	0.5	of Death (Check		6 ☐Other (Spec	
Division of Vital	or Attending Physician: The liter death. Director: After this certificate ha in by the funeral director, page	atlon; To	27. Manner of Death  Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Y	28b. Time of	28c. Injui Wor		28d. Desc		njury occurred	niy)
Divis	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc. (	- At home, farm, stre Specify)	eet, factory, office		28f. Locat City o	ion (Street or Town, St	a <i>nd Number</i> or <i>R</i> u ate)	ral Route Number,
	e Hospit 124 hour e Funera letely fille	edical (	29a. Certifier Check only one) Certifying Phys	ician: To the best of r er: On the basis of ea and manner state	camination and/or inv	occurred at the time time of the stigation, in my of	ne, date an pinion, dea	d place, and due to th occurred at the	the cause time, date a	(s) and manner as and place, and due	stated. to the cause(s)
)	To th withir To th comp	Me	29b. Signature and title of certified	role mo	1	29c. Licens	e number	£3	-	pril 27	, Day, Year)
	311		30. Name and address of person the con		th (Item 23a) (Type,	Print) Dri	سو (	Hen Bur	ուն , 1	MD 2108	,
Į	Sta Regist		31. Date filed (Month, Day, Year)  APR 2 8 2005	32. Registrar's	Signature		-				

			Please T	ype or Print in Bla	ck In	delible lnk	. Ensure A	II Copies A	Are Legible.	
			For State	State of Maryland	Depa	artment of H	lealth and M		-	
			Registrar  1. Decedent's Name (First, Middle, Last)		Cei	tificate of	Death	2. Date of Death	g. No./ [ ] [ ] 5	14428
	Physici /Medic		I RMA		R	UDICH		APRIL 2		3. Time of Death
	Examin	_	4a. Facility Name (If not institution, give s	street and number)		4b. City, Town, o	r Location of Death		4c. County of Deat	th
			STELLA MARIS HOS				TIMONIU			BALTIMORE
	Funeral		5. Social Security Number 6. Sex	IM SETE	birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, JUN. 20,	9. Birt	hplace (State or Foreign
_	Director		218-36-4769	67 (A)	113.			JUN. ZU,	1937	GERMANY
	yland		10a. State 10b. County	10c. City, To	own or Lo	cation				10d. Inside City Limits
	e Mar	ctor	MD BALTI	MORE	BALT	IMORE				1 □Yes 2 No
	or 28	Funeral Director	10e. Street and Number			10f. Zip Code	1	10	g. Citizen of What Co	
	ath w	rai	3204 OLD POST DR				21208			USA
	ltems	nne	11. Marital Status 1 ☐ Never Married 2 💢 Married	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🂢 No	13. \	Was Decedent of H f Yes, specify Cubi	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit	
336	irs af	by F	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1□Yes 2X No	Specify:		Specify:	WHITE
21215-0036	72 hou	ted	15. Decedent's Edu (Specify only highest grade	cation 10	6a. Deced	lent's Usual Occup	ation	· 1	6b. Kind of Business/	Industry
21	ithin 7	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	lite. I	DO NOT use retire	during most of work d)	iiig		
12	be filed within 72 hours after death with the Maryland that Hygiene. od other then "neturel", or flems 23a or 28a-f ahow event, the Medical Exacilier must be rigitled at		17. Father's Name (First, Middle, Last)		SALE	5	18. Mother's Name	- /First Middle N	foidos Cumana)	RETAIL
and	ed tale	Be c	HANS	BAUMA	MM		JULIE	e (1 1/51, IVIIGUIE, IV	aluen Suname)	COHEN
Maryland	2 should be filed within and Mental Hygiene. Is marked other then aumatic event, Ite Ma	2	19a. Informant's Name/Relationship (Type			ng Address (Street		al Route Number,	City or Town, State, 2	
	t and 2 Health a tem 27 Is		BORIS RUDICH / H	USBAND	3204	OLD POS	T DRICE #:	10 <b>-</b> BAL	TIMORE, MD	21208
J.G	es 1 a of He of He r othe		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ R		of Dispo	sition (Name of natory or other place	ce) !	Date 2	Oc. Location - City or	Town, State
Ë	Pages ment of H ant: If its		'4 □Donation 5 □ Other (Specify)	BALTI	MORE	HEBREW (	CEM. 04/2	8/2005	REISTER	STOWN, MD
Baltimore,	permit. Pages 1 and 2 should Department of Health and Men Important: If item 27 Is marke any injury or other traumatic once.		21. Signature of Funeral Service License	90	- 1	. Name and Addre			ON & BROS.	
	40240		23a. Part1. Enter the disease, or compli	cations that caused the death. F					IKESVILLE,	MD 21208 Approximate
	Physician		shock, or heart failure. List only or Immediate Cause (Final	ne cause on each line.			•	, , , , , , , , , , , , , , , , , , , ,		Interval Between Onset and Death
7	/Medical		disease or condition resulting in death)	Due to (or as a consequent		<u>R</u>				
	Examiner		Sequentially list conditions							
	P ≅	iner	Tany, leading to the rectale cause. Enter Underlying	Due to (or as a consequent	ne offi					
	secuted and I-transit	xamin	Cause (Disease or injury that initiated events resulting in death) Last	. Due to (or as a consequence	ra of)·	_				
68760,	be exician buria	ai Ex			<i>26</i> 01).					
687	ficate physis the	edic		l						
Box	The law requires that the death certificate be executed the sace signed by the attending physician and oate 2 should be detached for use as the burial-transit	Physician/Medical	23b. Was decedent bredhant	3c. If yes, outcome of pregnancy					23d. Date of del	ivery
	se death the atte	sicia	in the past 12 months? 1 □ Yes 2 No	1 Live birth 2 Fetal dea 4 Pregnant at time of death 9 Unknown		Ectopic pregnancy Other (specify)			Month	Day Year
P.0	that the de ed by the detached	Phy	9 Unknown		- i	4.4.5	- '- D I	nn- Dida-b		About a superior of decayle 0
Š	signed d be de	by	Part II. Other significant conditions con	tributing to death but not resultin	g in the ui	nderiying cause giv	en in Part I.		acco use contribute to	obably 4X Unknown
Ö	w requir been si should	etec								
Records,	ne law has ge 2 s	Completed			-			24a. Was an autopsy perform	prior to d	topsy findings available completion of cause of
Vital			25. Was case referred to medical				26. Place of Deatl	perform		2□ No
>	Physician: this certific ral director,	To Be	eyaminer?	lospital: 1 ☐ Inpatient 2 ☐ ER/	Outpatien	t 3 DOA Oth	0.00		nce 6XIOther (Spec	cify) HOSPICE
Jo u			27. Manner of Death		o. Time of Injury		y at	28d. Describe how		, HOULIGE
Siol	Attending r death. sctor: After by the fune	catic	2 Accident investigation		,,		Yes 2 ☐ No			
Division	in Life	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At home building, etc. (Specify)	farm, str	eet, factory, office		28f. Location (Str. City or Town,	eet and Number or Ru State)	ral Route Number,
ш	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in		29a. Certifier X Certifying Phys	sician: To the best of my knowled	dge, death	occurred at the fir	ne, date and place	and due to the co	use(s) and manner as	stated
	To the Hospital within 24 hours a To the Funeral I completely filled	Medical	(Check only 2 Medical Examinate)	ner: On the basis of examination and manner stated.	and/or inv	estigation, in my o	pinion, death occurr	ed at the time, da	te and place, and due	to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier			29c. Licens	e number	29	d. Date signed (Monti	
	1		12			143	725		4/27/	105

State Registrar

DHMH 17 Rev 1/2001

TIMONIUM, MD 21093

2300 DULANEY VALLEY RD.

32. Resistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. TARIQ MAHMOOD

31. Date filed (Month, Day, Year)

APR 2 8 2005

	Type or Print							_	<b>.</b>
For	State of Mai		-			Mental Hy	/giene	•	
State Registrar			Certi	ficate of	Death		Reg. No	200	7- 11-1-
1. Decedent's Name (First, Middle, La	ast)					2. Date of D	eath Da	v Ye	3. Time of Death
CAROL ANNE RABI	INOWITZ					HO21	2	200	- 1 - 1
a. Facility Name (If not institution, gir	ve street and number)		4	4b. City, Town,	or Location of De	ath	40	County of E	Peath
NORTH ARUN	DEL HOS	OITAL	(	GLEN B	BURNIE	•	1	INNE	ARUNDEL
,		n yrs. last birth		If Under 1 Year Months Days			rth	9.	Birthplace (State or Foreign Country)
214-46-1816	1□M 2XF	58 Y	rs.	violitis Days	Tiodis Wil	04/12			MD
Usual Residence of Decedent		in ob T							
10a. State 10b. County		10c. City, Town	or Loca	tion					10d. Inside City Limits
MD ANNE AF	RUNDEL	GAMBR I	LLS						1 ☐ Yes 2XXNo
10e. Street and Number				10f. Zip Code			10g. Ci	izen of Wha	Country?
1007 ANNAPOLIS F	ROAD			21054				USA	
11. Marital Status	12. Was Decedent Ev Armed Forces?	er in U.S.	13. Wa	as Decedent of es, specify Cub	Hispanic Origin?	(Specify Yes or N erto Rican, etc.)	0-		vmerican Indian, Vhite, etc.
1 Never Married 2 Married	1 ☐ Yes 2XXVIII		_	Yes <b>ADX</b> No		,,		Specify: W	
3 ☐ Widowed M∑Divorced	Year or Dates:			- 3FV				Specify. W	HILLE
15. Decedent's E (Specify only highest gi	ducation rade completed)		(Give kir	nt's Usual Occu nd of work done	during most of w	ronking	16b. K	ind of Busine	ess/Industry
Elementary/Secondary (0-12)	College (1-4or 5+	)		NOT use retire		DTC	TIT	DE DDG	ME OUT ON
	4	FIR	CE F.	IGHTER	/ PARAME				TECTION
17. Father's Name (First, Middle, Las						ame (First, Middle		•	
CHARLES OMAR SMI	LTH				DOROTH	Y PAULIN	E FI	TSCHEN	
19a. Informant's Name/Relationship	(Type, Print)	19b.	Mailing	Address (Stree	t and Number or i	Ru <i>ral R</i> oute Numl	er, City	or Town, Stat	e, Zip Code)
MS. STACY TAYLOR									
	R / DAUGHTER				LIS ROAD	, GAMBR			
20a. Method of Disposition	· · · · · · · · · · · · · · · · · · ·	20b. Place of	Disposit		=!	, GAMBR			1054 or Town, State
	Removal from State	20b. Place of cemetery	Disposit , crema	ion (Name of	300)		20c. L	ocation - City	
20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 [	□Removal from State	20b. Place of cemetery	Disposit , crema HIL	ion (Name of tory or other pla	ERY 4/	Date 27/2005	20c. L BR	ocation - City	or Town, State  MARYLAND
20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 [ 14 ☐ Donation 5 ☐ Other (Spec	□Removal from State	20b. Place of cemetery	Disposit , crema HIL	ion <i>(Name of tory or other pla</i> L CEMET  Name and Addr	ERY 4/	Date  27/2005  SINGLET	20c. L BR ON F	ocation - City OOKLYN UNERAL	or Town, State
20a. Method of Disposition  1 XBurial 2 ☐ Cremation 3 I  1 4 ☐ Donation 5 ☐ Other (Spec  21. Signature of Funeral Service Lice  23a. Part1. Enter the disease, or cor	□Removal from State ify) ensee  anciest molications that caused the	CEDAR  MO1357  ne death. Do no	Disposit v, crema HIL	ion (Name of tory or other pla L CEMET Name and Addr	ERY 4/ ess of Facility OND AVE,	Date 27/2005 SINGLET SW, GL	BR ON F EN B	ocation - City OOKLYN UNERAL	MARYLAND HOME, P.A. MD 21061 Approximate
20a. Method of Disposition  1 ABurial 2 Cremation 3 I  4 Donation 5 Other (Spec  21. Signature of Funeral Service Lice  23a. Part1. Enter the disease, or corshock, or heart failure. List only	□Removal from State ify) ensee  anciest molications that caused the	CEDAR MO1357 ne death. Do not	Disposit c, crema HILI 22. N	ion (Name of tory or other pla  L CEMET Name and Addr  1 SEC the mode of dy	ERY 4/ ess of Facility OND AVE,	Date  27/2005  SINGLET SW, GL ac or respiratory a	BR ON F EN B	ocation - City OOKLYN UNERAL	, MARYLAND HOME, P.A. MD 21061
20a. Method of Disposition  1 ⊠Burial 2 □ Cremation 3 I  1 □ Other (Spec  21. Signature of Funeral Service Lice  23a. Part1. Enter the disease, or corshock, or heart failure. List only	Removal from State	CEDAR M01357 ne death. Do no.	Disposit c, crema HIL 22. Not enter	ion (Name of tory or other pla  L CEMET Name and Addr  1 SEC the mode of dy	ERY 4/ ess of Facility OND AVE,	Date  27/2005  SINGLET SW, GL ac or respiratory a	BR ON F EN B	ocation - City OOKLYN UNERAL	, MARYLAND HOME, P.A. MD 21061 Approximate Interval Between
20a. Method of Disposition  1	□Removal from State ify) ensee  anciest molications that caused the	CEDAR M01357 ne death. Do no.	Disposit c, crema HIL 22. Not enter	ion (Name of tory or other pla  L CEMET Name and Addr  1 SEC the mode of dy	ERY 4/ ess of Facility OND AVE,	Date  27/2005  SINGLET SW, GL ac or respiratory a	BR ON F EN B	ocation - City OOKLYN UNERAL	, MARYLAND HOME, P.A. MD 21061 Approximate Interval Between
20a. Method of Disposition  1	Removal from State	20b. Place of cametery CEDAR  M01357 ne death. Do not consequence of	Dispositive, crema HILI 22. Not enter S7	ion (Name of tory or other pla  L CEMET Name and Addr  1 SEC the mode of dy	ERY 4/ ess of Facility OND AVE,	Date  27/2005  SINGLET SW, GL ac or respiratory a	BR ON F EN B	ocation - City OOKLYN UNERAL	, MARYLAND HOME, P.A. MD 21061 Approximate Interval Between
20a. Method of Disposition  1 ABurial 2 Cremation 3 I  4 Donation 5 Other (Spec  21. Signature of Funeral Service Lice  23a. Part1. Enter the disease, or corshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or inpury)	Removal from State (ify) ensee  ancest from State (ify) ensee	20b. Place of cametery CEDAR  M01357 ne death. Do not consequence of	Dispositive, crema HILI 22. Not enter S7	ion (Name of tory or other pla  L CEMET Name and Addr  1 SEC the mode of dy	ERY 4/ ess of Facility OND AVE,	Date  27/2005  SINGLET SW, GL ac or respiratory a	BR ON F EN B	ocation - City OOKLYN UNERAL	, MARYLAND HOME, P.A. MD 21061 Approximate Interval Between
20a. Method of Disposition  1 ABurial 2 Cremation 3 I  4 Donation 5 Other (Spec  21. Signature of Funeral Service Lice  23a. Part1. Enter the disease, or corshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate gause. Enter Underfying	mplications that caused the yone cause on each line.  Due to (or as a b.  Due to (or as a c.	20b. Place of cametery CEDAR  M01357  ne death. Do not consequence of consequence of consequence of consequence of cameters.	Disposite, crema HILI 22. Not enter S7 ff):	ion (Name of tory or other pla  L CEMET Name and Addr  1 SEC the mode of dy	ERY 4/ ess of Facility OND AVE,	Date  27/2005  SINGLET SW, GL ac or respiratory a	BR ON F EN B	ocation - City OOKLYN UNERAL	, MARYLAND HOME, P.A. MD 21061 Approximate Interval Between
20a. Method of Disposition  1	Removal from State (ify) ensee  ancest from State (ify) ensee	20b. Place of cametery CEDAR  M01357  ne death. Do not consequence of consequence of consequence of consequence of cameters.	Disposite, crema HILI 22. Not enter S7 ff):	ion (Name of tory or other pla  L CEMET Name and Addr  1 SEC the mode of dy	ERY 4/ ess of Facility OND AVE,	Date  27/2005  SINGLET SW, GL ac or respiratory a	BR ON F EN B	ocation - City OOKLYN UNERAL	, MARYLAND HOME, P.A. MD 21061 Approximate Interval Between
20a. Method of Disposition  1 Aburial 2 Cremation 3 I  4 Donation 5 Other (Spec  21. Signature of Funeral Service Lice  23a. Part1. Enter the disease, or conshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or impury that initiated events	mplications that caused the yone cause on each line.  Due to (or as a b.  Due to (or as a c.	20b. Place of cametery CEDAR  M01357  ne death. Do not consequence of consequence of consequence of consequence of cameters.	Disposite, crema HILI 22. Not enter S7 ff):	ion (Name of tory or other pla  L CEMET Name and Addr  1 SEC the mode of dy	ERY 4/ ess of Facility OND AVE,	Date  27/2005  SINGLET SW, GL ac or respiratory a	BR ON F EN B	ocation - City OOKLYN UNERAL	, MARYLAND HOME, P.A. MD 21061 Approximate Interval Between
20a. Method of Disposition  1 \( \tilde{\mathbb{A}} \) Burial 2 \( \tilde{\mathbb{C}} \) Cremation 3 \( \tilde{\mathbb{C}} \)  3 \( \tilde{\mathbb{C}} \) Other (Spec 21. Signature of Funeral Service Lice 22a. Part1. Enter the disease, or cor shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that infliated events resulting in death) Last	Bemoval from State (ify) ansee  ance mplications that caused it y one cause on each line a.  Due to (or as a b.  Due to (or as a c.  Due to (or as a d.	20b. Place of cametery CEDAR  M01357  ne death. Do not consequence of consequence	Disposite, crema HILI 22. Not enter S7 ff):	ion (Name of tory or other pla  L CEMET Name and Addr  1 SEC the mode of dy	ERY 4/ ess of Facility OND AVE,	Date  27/2005  SINGLET SW, GL ac or respiratory a	BR ON F EN B	OOKLYN UNERAL URNIE,	MARYLAND HOME, P.A. MD 21061 Approximate Interval Between Onset and Death
20a. Method of Disposition  1 ABurial 2 Cremation 3 I  4 Donation 5 Other (Spec  21. Signature of Funeral Service Lice  23a. Part1. Enter the disease, or conshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Unsease or Injury that intilated events resulting in death) Last	Bernoval from State ify) ansee  ance mplications that caused it y one cause on each line  a.  Due to (or as a b.  Due to (or as a c.  Due to (or as a d.  23c. If yes, outcome of 1 Live birth 2	20b. Place of cametery CEDAR  M01357  ne death. Do not consequence of consequence	Disposit, crema HILI 22. N ot enter S7 ff):	ion (Name of tory or other piz L CEMET Name and Addr 1 SEC the mode of dy	ERY 4/ ess of Facility OND AVE, ing, such as cardi	Date  27/2005  SINGLET SW, GL ac or respiratory a	BR ON F EN B	ocation - City OOKLYN UNERAL	MARYLAND HOME, P.A. MD 21061 Approximate Interval Between Onset and Death
20a. Method of Disposition  1 \( \tilde{\mathbb{A}} \) Burial 2 \( \tilde{\mathbb{C}} \) Cremation 3 \( \tilde{\mathbb{C}} \)  3 \( \tilde{\mathbb{C}} \) Other (Spec 21. Signature of Funeral Service Lice 23a. Part1. Enter the disease, or cor shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that infliated events resulting in death) Last  IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1 \( \tilde{\mathbb{C}} \) Yes 2 \( \tilde{\mathbb{D}} \) No	Bemoval from State (ify) ansee  ance Dance In that caused it yone cause on each line a. Due to (or as a b. Due to (or as a d.  Due to (or as a d.	20b. Place of cametery CEDAR  M01357  ne death. Do not consequence of consequence	Disposit, crema HILI 22. N ot enter S7 ff):	ion (Name of tory or other plate L CEMET Name and Addr 1 SEC) the mode of dy	ERY 4/ ess of Facility OND AVE, ing, such as cardi	Date  27/2005  SINGLET SW, GL ac or respiratory a	BR ON F EN B	OOKLYN UNERAL URNIE,	MARYLAND HOME, P.A. MD 21061 Approximate Interval Between Onset and Death
20a. Method of Disposition  1	Bemoval from State (ify) ansee  ance Dance I are the property one cause on each line a.  Due to (or as a b.  Due to (or as a d.  23c. If yes, outcome of 1 Live birth 2 4 Pregnant at ti 9 Unknown	20b. Place of cametery CEDAR  M01357  The death. Do not consequence of consequenc	Disposit  , crema  HILI  22. N  ot enter  of):  f):	ion (Name of tory or other piz L CEMET Name and Addr 1 SEC the mode of dy	ese of Facility OND AVE, ing, such as cardi	Date  27/2005  SINGLET SW, GL ac or respiratory	BRON FEN Barrest,	OOKLYN OOKLYN UNERAL URNIE,	MARYLAND HOME, P.A. MD 21061 Approximate Interval Between Onset and Death  delivery Day Year
20a. Method of Disposition  1	Bemoval from State (ify) ansee  ance Dance I are the property one cause on each line a.  Due to (or as a b.  Due to (or as a d.  23c. If yes, outcome of 1 Live birth 2 4 Pregnant at ti 9 Unknown	20b. Place of cametery CEDAR  M01357  The death. Do not consequence of consequenc	Disposit  , crema  HILI  22. N  ot enter  of):  f):	ion (Name of tory or other piz L CEMET Name and Addr 1 SEC the mode of dy	ese of Facility OND AVE, ing, such as cardi	Date  27/2005  SINGLET SW, GL  ac or respiratory at the second se	BRON FEN Barrest,	OOKLYN UNERAL URNIE,	delivery Day Year
20a. Method of Disposition  1	Bemoval from State (ify) ansee  ance Dance I are the property one cause on each line a.  Due to (or as a b.  Due to (or as a d.  23c. If yes, outcome of 1 Live birth 2 4 Pregnant at ti 9 Unknown	20b. Place of cametery CEDAR  M01357  The death. Do not consequence of consequenc	Disposit  , crema  HILI  22. N  ot enter  of):  f):	ion (Name of tory or other piz L CEMET Name and Addr 1 SEC the mode of dy	ese of Facility OND AVE, ing, such as cardi	Date  27/2005  SINGLET SW, GL  ac or respiratory at the second se	BRON FEN Barrest,	OOKLYN UNERAL URNIE,	MARYLAND HOME, P.A. MD 21061 Approximate Interval Between Onset and Death  delivery Day Year
20a. Method of Disposition  1 \( \text{A} \) Burial 2 \( \text{Cremation} \) 3 \( \text{Cremation} \) 4 \( \text{Donation} \) 5 \( \text{Other} \) (Spec 21. Signature of Funeral Service Lice 23a. Part1. Enter the disease, or conshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1 \( \text{Yes} \) 2 \( \text{No} \) 9 \( \text{Unknown} \)	Bemoval from State (ify) ansee  ance Dance I are the property one cause on each line a.  Due to (or as a b.  Due to (or as a d.  23c. If yes, outcome of 1 Live birth 2 4 Pregnant at ti 9 Unknown	20b. Place of cametery CEDAR  M01357  The death. Do not consequence of consequenc	Disposit  , crema  HILI  22. N  ot enter  of):  f):	ion (Name of tory or other piz L CEMET Name and Addr 1 SEC the mode of dy	ese of Facility OND AVE, ing, such as cardi	Date  27/2005  SINGLET SW, GL  ac or respiratory a  23e. Did  10  24a. Wa	20c. L BR ON F EN B arrest,	23d. Date of Month	delivery Day Year  e to the cause of death? Probably 4 Unknown
20a. Method of Disposition  1 \( \text{A} \) Burial 2 \( \text{Cremation} \) 3 \( \text{Cremation} \) 4 \( \text{Donation} \) 5 \( \text{Other} \) (Spec 21. Signature of Funeral Service Lice 23a. Part1. Enter the disease, or conshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1 \( \text{Yes} \) 2 \( \text{No} \) 9 \( \text{Unknown} \)	Bemoval from State (ify) ansee  ance Dance I are the property one cause on each line a.  Due to (or as a b.  Due to (or as a d.  23c. If yes, outcome of 1 Live birth 2 4 Pregnant at ti 9 Unknown	20b. Place of cametery CEDAR  M01357  The death. Do not consequence of consequenc	Disposit  , crema  HILI  22. N  ot enter  of):  f):	ion (Name of tory or other piz L CEMET Name and Addr 1 SEC the mode of dy	ese of Facility OND AVE, ing, such as cardi	Date  27/2005  SINGLET SW, GL  ac or respiratory and the second of the s	20c. L BR ON F EN B arrest,	23d. Date of Month	delivery Day Year  e to the cause of death? Probably 4 Unknown decompletion of cause of 12

Physician /Medical Examiner

**Physician** 

/Medical

**Examiner** 

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mantal Hyglene. Importent: If Item 27 Is marked other then "naturel", or Items 23e or 28e-f show any injury or other treumatic event, Ir.e. Madical Exarchiner statics inclined at once.

To Be Completed by Funeral Director

To the Hospitel or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.

Ye the Funerel Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Medical Certification; To Be Completed by Physician/Medical Examiner

IF FEMALE:	
23b. Was decedent pregnant	
in the past 12 months?	
1 ☐ Yes 2 🖾 No	
9 Unknown	

Part II	Other significa	nt conditions of	ontributing to dea	th but not resultin	g in the underlying	cause given in Part	1.
							_

s case referred to medical miner?							
Yes 2 No	Hospita	spital: 1XI	npatient	2	ER/Outpatient	3 🗆 (	DOA
nner of Death		28a. Date	of Injury	200	28b. Time of		28c. l

	. I lado di bodin (bi		
Other:	4 🗌 Nursing Home	5 🗆 Residence	6 ☐Other (Specify)
niiin/ at		Describe how init	

25. Was case referred examiner?		Hospital: 1 Inpatient
27. Manner of Death  1 Natural  2 Accident	5 Pending investigatio	28a. Date of Injury (Month, Day Ye
3 Suicide	6 Could not be determined	28e. Place of Injury

(ear)	Injury		Work?	
		М	1 🗆 Yes	2 🗆
- At h	ome, farm, stree	t, fact	ory, office	

Work? 1 ☐ Yes 2 ☐ No	25d. Bescribe now injury occurred
y, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)

a. Certifier	112 Certifying Physician: To the best of my knowledge, death occurre
(Check only one)	2 Medical Examiner: On the basis of examination and/or investigation and manner stated.

irred at the time, date and	place, and due to the cause(	
		nd place, and due to the cause(s)
,, .,,		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,

GLEN

29b. Signature	and title of certifier	0
	1/	1
	Der	Ce

1	00	55	7	0	3
* /	$\omega$	00	/	$\sim$	_

Wospin

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1310 N

OLTH AMUNDER 32/Registrar's Signature

		-	For State	State of Mar	-	epartment of H Certificate of I				
			Registrar  1. Decedent's Name (First, Middle, Las	st)			Douth	2. Date of Deat		3. Time of Death
	Physicia		Ethel Vi	rginia	Reed			Month		9/5 AM
	/Medic Examin		4a. Facility Name (If not institution, give			4b. City, Town, or	Location of Death	gnes	4c. County of	Death ,
			304 JOPPA C	ROSSING	WAY	To	PPA		HAR	FORD
	Funeral Director		5. Social Security Number 6. S 212–56–5900	ex 7. Age ( ☐ M 2	In yrs. last birth	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, March 2	Year) 9.	Birthplace (State or Foreign Country) Maryland
			Usual Residence of Decedent					Haren 2	, 1505	rior y zunu
	trylan show	_	10a. State 10b. County	1	0c. City, Town					10d. Inside City Limits
	8a-fs	Sch	Ohio Butle	r		Fairfield				1 ☐ Yes 2 📆 No
	with th	Ö	10e. Street and Number	_		10f. Zip Code		1	0g. Citizen of Wha	•
	s 23	eral	89 Twin Lakes D	12. Was Decedent Ev	er in II S	13 Was Decedent of H	45014	ecify Ves or No-	USA 14 Bace -	American Indian,
	fter d	Funeral Director	1 Never Married 2 Married	Armed Forces?	61 111 0.0.	<ol> <li>Was Decedent of H If Yes, specify Cuba</li> </ol>	n, Mexican, Puerto	Rican, etc.)		White, etc.
036	urs al	by	3 ₩ Widowed 4 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 💢 No	Specify:		Specify:	White
21215-0036	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or Itams 23a or 28a-f show that the Madical Exandred must be notified a	Completed	15. Decedent's Ed (Specify only highest gra		16a. l	Decedent's Usual Occup	ation during most of work	ina	16b. Kind of Busin	ess/Industry
21	ithin an "	nple	Elementary/Secondary (0-12)	College (1-4or 5+)		Give kind of work done of life. DO NOT use retired	i)			
	led w lygier her ti		11 17. Father's Name (First, Middle, Last)	n/a		Homemaker	19. Mathada Nam	o /First Middle I	Own F Maiden Sumame)	lome
anc	I be findal Pad ot	Be	_		.13		Sarah	e (Filst, Middle, F	Kea	dv
Maryland	2 should be filed withir and Mental Hygiene. Is markad other than surmatic evant, the M.	ဥ	Robert  19a, Informant's Name/Relationship (	Reyna Type, Print)		Mailing Address (Street		al Route Number		
Ma	and 2 sealth an n 27 is		Kenneth T. Reed/S			Twin Lakes				45014
ē,	f Hea f Hea itam otha	110	20a. Method of Disposition		20b. Place of	Disposition (Name of crematory or other place		Date	20c. Location - Cit	y or Town, State
Ę	Pages nent of H int: if its iry or o		1 ☐ Burial 2 🛣 Cremation 3 ☐  '4 ☐ Donation 5 ☐ Other (Specif		·	ore-Washing	4/20		Laurel.	Maryland
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if itam 27 is marked other than "natural", or itams 23a or 28a-1 show any injury or other traumatic event, the Mardical Equitation must be notified at once.		Bryan W. Clary	Caret		Lemmon Fun 10 W. Pado	ss of Facility eral Home	of Dula	aney Vall	
			23a. Part1. Enter the disease, or com shock, of heart fallure. List only	plications that caused the	ne death. Do n					Approximate Interval Between
ı	Physician		Immediate Cause (Final disease or condition	To		Posotio. Co	2.0.	· la	di	Onset and Death
7	/Medical		resulting in death)	Due to (or as a	consequence o	i):	uction	scivi	n as	Care
	Examiner		Sequentially list conditions	b						
3	p #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequence o	f):				
V	cate be executed physician and the burial-transit	Examiner	that initiated events resulting in death) Last	c Due to (or as a	200000000000000000000000000000000000000	ь.				
8760,	be ex ician burial	E E		Due to (or as a	consequence o	.,.				
387		dical		d						
×	The law requires that the death certific te has been signed by the attending property 2 should be detached for use as	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of					23d. Date o	f delivery
Box	death a atter d for u	ciar	in the past 12 months?	1□Live birth 2 4□Pregnant at tir		3 ☐ Ectopic pregnancy 5 ☐ Other (specify)	· ·		Month	Day Year
P.O.	t the c by the acher	hys	9 Unknown	9□ Unknown				ang -		
	ss tha gned	oy P	Part II. Other significant conditions of	contributing to death but	not resulting in	the underlying cause giv	en in Pan I.	23e. Did tol		te to the cause of death?
ord	w require been sign should b	ted	Culluscell	sour cer	etro	vascular	/ duscort	1 □ Ye	es 2 No 3	Probably 4 Unknown
Vital Records,		Completed						24a. Was a autops	n 24b. Wei	e autopsy findings available r to completion of cause of
E.		Con						perforr	med? dea	th? Yes 2 No
/ita	Physician: this certifical	Be	25. Was case referred to medical examiner?	Line-itali		101		th (Check only on		ENCE OF
of	도 요 =	10	1 Yes 2 No	Hospital:			4 🗆 Ivuising no	ome 5 Reside		Specify CAREGIVEX
n C	ding Phy h. After thi funeral c	lo	27. Manner of Death  1   ✓ Natural 5 ☐ Pending 2 ☐ Accident investigatio	28a. Date of Injury (Month, Day	Year) 28b. Ti	jury Wor	yat k? Yes 2 □No	28d. Describe no	ow injury occurred	
Division	death death ctor: y the	ficat	3 Suicide 6 Could not b	On Place of Laine	v - At home, far	m, street, factory, office	165 E	28f, Location (St	treet and Number	or Rural Route Number,
ο	after after Dira	erti	4 Homicide	building, efc.	(Specify)	,		City or Town	n, State)	
	To the Hospital or Attending P within 24 hours after death.  To the Funeral Director: After t completely filled in by the funeral	Medical Certification:	29a. Certifier 1 Certifying Pl (Check only one)	nysician: To the best of miner: On the basis of e and manner state	xamination and	death occurred at the tir	ne, date and place, pinion, death occur	and due to the cared at the time, d	ause(s) and manne ate and place, and	er as stated. I due to the cause(s)
	o the ithin 2 o tha	Med	29b. Signature and title of certifier	and manner state	<del>1</del> 0.	29c. Licens	e number	2	9d. Date signed (A	Month, Day, Year)
	⊢ ≯ ⊢ ŏ		Demail of	Libra 1	10 DME	= 100	14206			
	5		30. Name and address of person you	UKNA, M	ath (Nem 23a) (	70/8 H	LABIRE	AVE	BALTO	26,2005 Md 25222
	Sta		31. Date filed (Month, Day, Year)	32 Registrar	s Signature	breetes				
	Regist	rar	APR 2.8 21	JUS JUSTINE	15 1					

		-	State of I	Maryland / Department of Health and I Certificate of Death	Mental Hygiene	14431					
3	Physicia /Medic		1. Decedent's Name (First, Middle, Last)  NTLORED	REYNOLDS	2. Date of Death  Month Day Ye	at 03:54A					
	Examin Funeral	er	1 M W E	Age (In yrs ast birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Year)	N/A  Birthplace (State or Foreign Country) NNSYLVANIA					
÷	Director		192 44 2404  Usual Residence of Decedent  10a. State 10b. County	51 Yrs. 10c. City, Town or Location	AUG. 29, 1933 PE	10d. Inside City Limits					
	r 28a-f sh	Director	MD BALTIMORE  10e. Street and Number	N/A	10g. Citizen of Wha	1 ☐ Yes 2 🕱 No t Country?					
"	72 hours after death with the Maryland "natural", or Items 23s or 28a-f show rdical Examiner must be modified at	Funerai	6840 BELCLARE RD.  11. Marital Status  1 XNever Married 2 Married  1 Yes 2	s? If Yes, specify Cuban, Mexican, Puer	to Rican, etc.) Black, \	American Indian, White, etc.					
21215-0036	nn 72 hours a n "natural", o Wedical Exan	Completed by	3 Widowed 4 Divorced  15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4)	16a. Decedent's Usual Occupation (Give kind of work done during most of wo life. DO NOT use retired)	16b. Kind of Busin	BLACK ess/Industry					
ınd 212	be filed within 72 hc ntal Hygiene. id othar than "natui avent, the Medical	Be	2 YEARS  17. Father's Name (First, Middle, Last)  WILLIE REYNOLDS	XRAY TECHNICIAN  18. Mother's Na.	HOSPITAL me (First, Middle, Maiden Surname) AE JORDAN						
Maryland	nd 2 should th and Mer 27 Is marke traumatic	To	19a. Informant's Name/Relationship (Type, Print) FIOREE WHITERS (SISTER)	19b. Mailing Address (Street and Number or R. 2817 S. 81st ST. PHILA	ural Route Number, City or Town, Sta	te, Zip Code)					
Baltimore,	permit. Pages 1 and Department of Health Important: If itam 27 any injury or other tr once.		20a. Method of Disposition  1 \$360 hal 2 Cremation 3 Removal from St  4 2 Conation 5 Other (Specify)  21 Signature of Funeral Service Licensee	20b. Place of Disposition (Name of cemetery, crematory or other place)  MT. ZION CEMETERY APRIL 2  22. Name and Address of Facility C  1412 E. PRESTON ST		E.MD. FUNERAL HÖME					
	Pnysician		shock, or heart failure. List only one cause on each immediate Cause (Final disease or condition	used the death. Do not enter the mode of dying, such as cardia		Approximate Interval Between Onset and Death					
760, <	Medical Examiner  Ostocial and principle of the principle	icai Examiner	resulting in death)  Due to (or put to (or p	as a consequence of):  NOVARY HYPERTENSION as a consequence of):  as a consequence of):		GREATER THAIN  5 YEARS  GREATER THAIN  5 YEARS					
O. Box 68	death certific e attending pl id for use as t	by Physician/Medi	23b. Was decedent pregrant	ome of pregnancy  h 2 Fetal death 3 Ectopic pregnancy  nt at time of death 5 Other (specify)	23d. Date o						
4	w requires that the sbeen signed by th should be detache								th but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribu	ite to the cause of death?  ☐ Probably 4 ☑ Unknown
al Records,	The law ate has b	Completed	25. Was a se referred to medical	26 Place of Di	autopsy prio performed? dea	re autopsy findings available r to completion of cause of th? Yes 2 \sum No					
ion of Vital	ding Phys n. After this funeral di	ation: To Be	examiner?  1 Yes 2 No  27 Manner of Death 28a, Date of	patient 2 ER/Outpatient 3 DOA Cther: 4 Nursing	Home 5 Residence 6 Other 28d. Describe how injury occurred	(Specify)					
Division	in the second	Certification:	4 Homicide degrinmed building	if Injury - At home, farm, street, factory, office g, etc. ( <i>Specify)</i>	28f. Location (Street and Number City or Town, State)						
	류트로	Medical	(Check only 2 Madical Examiner: On the bar	20a License number	curred at the time, date and place, and	due to the cause(s)					
			Dring Citi, Mo	000538	64-5 April 24	th, 2005					
9:	3	ate	31. Date filed (Month, Day, Year) 32. P	IS HOPKING HOSPITAL MEYER 3- gistrar's Signature	181, 600 N. Wate ST., 1	BALTIMORE, MD 2120S					
Di	Regist	trar	APR 2 8 2005	on & fine							

ORIGINAL

			1 - For State Registrar	State of Maryland /	Department of Health Certificate of Deat		ental Hygie Reg.	2000	14432
	Physici /Medic	cal	1. Decedent's Name (First, Middle, Last) BARBARA 4a. Facility Name (If not institution, give s	NE SAVER	S 4b. City, Town, or Locatio	2	2. Date of Death	Day Year 55	3. Time of Death
i	Funeral Director	lei	40 UNION VA 5. Social Security Number 6. Sex	LLEY RD.	ELKTO	SNC	Date of Birth (Month, Day, Ye	CECV	pplace (State or Foreign Intry)
backgrown ed	Se-f show otified at	ector	Usual Residence of Decedent  10a. State  10b. County  CECIL	10c. City, To	wn or Location KTON				10d. Inside City Limits 1 ☐ Yes 2 ☐ No
J Ifter death with t	r Itams 23a or 2	Funeral Director	10e. Street and Number 10 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Of Yes, specify Cuban, Mexic		U	14. Race - Amer Black, White	STATES ican Indian,
1a) yiaild 21213-0030 2 should be filed within 72 hours after death with the Maryland	nt of Health and Mental Hygiene. If itam 27 is marked other than "natural", or Itams 23a or 28e-f show or other traumatic avant, Ita Medical Experient must be notified at	To Be Completed by	3 Widowed 4 Privorced  15. Decedent's Educ (Specify only highest grade) Elementary/Secondary (0-12)		a. Decedent's Usual Occupation (Give kind of work done during milfe. DO NOT use retired)		16b	Specify: Kind of Business/Ir	HITE
			17. Father's Name (First, Middle, Last)	AM MORE	JAUTY CON 18. Moi AND ES	TRUL ther's Name (I	First, Middle, Maio	OTOMO en Sumame) BANE	TIVE
OIC, Mai les 1 and 2 sh	of Health and If itam 27 is m or othar traum		19a. Informant's Name/Relationship (Type ROBERT MOREUA) 20a. Method of Disposition 1 Byzial 2 Cremation 3 Re	1D IL /SON 41 20b. Place 3	b. Mailing Address (Street and Num Disposition (Name of ary, cramatory or other place)	PRD: Dat	EUKTO	or Town, State, Zi Location - City or T	16910
permit. Pages	ant and		4 ☑ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service License	ANAT		y Family Fu		Cremation Centerena MD 21122	
1	nysician Medical		23a. Pa 1. Enter the disease, or shock, or heart failure. List hip on immediate Cause (Final disease or condition resulting in death)	ations the course on each line.  Due to (or s a consequence	Nan-Hodgle	as cardiac or r	espiratory arrest,	~<	Approximate Interval Between Onset and Death
cate be executed	this certificate has been signed by the attending I ral director, page 2 should be detached for use as	Il Examiner	Sequentially list conditions, it has been been cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence	<u></u>				
ng Physician: The law requires that the death certifi		Physiclan/Medical	JF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	c. If yes, outcome of pregnancy  1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown	n 3□Ectopic pregnancy 5□ Other (specify)			23d. Date of delive	ery Day Year
		by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to					he cause of death?	
		Medical Certification: To Be Completed	25. Was case referred to medical		26 Pla	ce of Death ((	24a. Was an autopsy performed? 1 Yes 2 Theck only one)	prior to co death?	psy findings available mpletion of cause of
			examiner?  1 Yes 2 No Ho  27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	ospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Hom		Nursing Home 28d	me 5 ⊒-Residence 6 □Other (Specify) 28d. Describe how injury occurred		
To the Hospital or Attending			3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  29a. Certifier  (Physician: To the best of my knowledge, death occurred at the time, date and place,			and place, and	28f. Location (Street and Number or Rural Route Number, City or Town, State) and due to the cause(s) and manner as stated.		
To the Ho			(Check only one) 2 Medical Examina  29b. Signature and title of certifier	or: On the basis of examination ar and manner stated.	d/or investigation, in my opinion, de 29c. License number	eath occurred	at the time, date a	ate signed (Month,	the cause(s)
	3		30. Name and address of person who com  Martha Hosford - X  31. Date filed (Month, Day, Year)	opport cause of death (Item 23a)  opport M.O. /// U.  32. Registrar's Signature	(Type, Print) St, #101 E	KHON!	108	-45-6	3
	Sta Registr		ADD 9 9 000	L	links.				

**ORIGINAL** 

05-02853 Annie Smith RJD

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	JIII CII		1 - For State Registrar	State of M	aryland / Depa <i>Ce</i> a	artment of H			iene <sub>eg. No.</sub> 2005	5 11.10					
	Physic /Medi		Decedent's Name (First, Middle, I Annie	.ast)	Smith			2. Date of Deat April 2	3, Day 2005 Year	3. Time of Death 1339P. M					
	Examir		4a. Facility Name (If not institution, g 1726 Washington	St.		Baltimor			4c. County of Death	1					
	Funeral Director		5. Social Security Number 6. 219–56–2923  Usual Residence of Decedent	Sex 7. Ag 1 ★ M 2 □ F 7.	ge (In yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth	9. Birth Cou	nplace (State or Foreign untry) N.C.					
	Maryland -f show	tor	10a. State 10b. County  Md. NA		10c. City, Town or Lo					10d. Inside City Limits Y☐ Yes 2 ☐ No					
	death with the Maryland ms 23e or 28a-f show	al Direc	10e. Street and Number 1726 N. Washing	ton Street		10f. Zip Code 212]	.3	10	0g. Citizen of What Cou USA	intry?					
36	172 hours after death with the Marylan "naturel", or items 23e or 28a-f show idical Examination institution at	by Funer	11. Marital Status  1 □ Never Married 2 □ Married  3 ☑ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes 2 X If Yes, Give Year or Dates:	No I	Was Decedent of Hi f Yes, specify Cuba 1 ☐ Yes 2X No	spanic Origin? (Sp n, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White Specify:						
21215-0036	within 72 hou ene. then "nature he Wedical E	Completed by Funeral Director	15. Decedent's (Specify only highest of Elementary/Secondary (0-12) 12th grade	Education	(Give 5+)	dent's Usual Occupa kind of work done of DO NOT use retired	ation furing most of work )	ring	  16b. Kind of Business/li     Other Peop	ndustry					
	2 should be filed withir and Mental Hygiene. Is marked other than eumatic event, the M	To Be Co	17. Father's Name (First, Middle, La.  James	st)	Baker	lestic	18. Mother's Nam	e (First, Middle, N		Le nomes					
, Maryland	and 2 shoulath and Market 157 is mailer treumate		19a. Informant's Name/Relationship	(Type, Print)  Father					City or Town, State, Zi	ip Code) 21213					
Baltimore,	Pages 1 ament of He ent: If iten ury or oth		20a. Method of Disposition  1 DBurial 2 Cremation 3  4 Donation 5 Other (Spec		20b. Place of Disponsion Commetery, crem	natory or other plac	9)		20c. Location - City or T Dundalk, Mc						
Balt	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Importent: If item 27 is marked other than eny injury or other treumatic event, the Macone.		21. Signature of Funeral Service Lic	gotnom	M	Name and Address Rarch F.H.	East	1101 E	imore, Md. . North Ave	21202 e.					
ł	Pnysician /Medical Examiner		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a												
8760,	cate be executed physician and the burial-transit	dical Examiner	Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	a consequence of):										
.O. Box 68	death certifi e attending od for use as	by Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of deliv Month	ery Day Year					
Δ.	requires that the een signed by th nould be detache		Part II. Other significant conditions	contributing to death b	ut not resulting in the u	nderlying cause give	n in Part I.	23e. Did tob	acco use contribute to t						
Il Records,	The law recate has bee page 2 sho	Completed						24a. Was an autopsy perform	prior to co	opsy findings available ompletion of cause of					
of Vital	ding Physicien: The lav h. After this certificate has funeral director, page 2	To Be	25. Was case referred to medical examiner?  XXYes 2 \sum No	Hospital: 1 ☐ Inpatie			4   Nursing no	me 5 Resider	nce 6 XIOther (Specia	w(scene)					
Division o	Attending Frdeath. sctor: After by the funera	27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 4 Homicide 6 Could not be determined 28e. Date of Injury 28b. Time of Injury Work?  28d. Describe 28d. Des													
Div	To the Hospital or Attenc within 24 hours after death To the Funerel Director: completely filled in by the I		4  Homicide determine	building, et	c. (Specify)			City or Town,							
	o the Hos ithin 24 hc o the Fun ompletely	Medical	(Check only one)  29b. Signature and title of cartifier	aminer: On the basis o and manner sta	f examination and/or inv	estigation, in my op	inion, death occurr	ed at the time, da	use(s) and manner as s te and place, and due to d. Date signed (Month,	o the cause(s)					
	with To		• ),	M. To		O.C.M			oril 23, 20						
	3		30. Name and address of person who says the same and address of person who says and says are says and says are says and says are says and says are says and says are says and says are says and says are says and says are says and says are says are says and says are says and says are says and says are says and says are says are says are says and says are says and says are says are says are says and says are says are says are says and says are	Tipes 1	leath (Item 23a) (Type, 10 kg)  Ar's Signature	111 Per	nn St., E	Baltimore	e, Maryland	21201					
8,-	Sta Registi		APR 2 8 200	0	A Soor	E .									

05-02789 LEROY SPANN WHM

<b>Physici</b>	ian	Decedent's Name (	(First, Middle, L								2. Date of De	ath	200:	3. Time of Deal
/Medi		Ler				S	pann				APRIL		2005	5:58 P
Examir	ner	JOHNS HOPE	KINS HO	SPITAL ER	or)		4b. City, To BALT]	EMOR				4c.	NA	ath
uneral irector		5. Social Security Num		Sex 7.7 1 M 2□F	Age (In yrs. la 56	yrs.	Months (	Year Days	If Under a	Min.	8. Date of Bir	th 148 (ear)	g. Bir	rthplace (State or For ountry) S.C.
*		Usual Residence of D 10a. State 1	ecedent 10b. County		10c. City.	Town or Lo	ocation							10d. Inside City Lin
f aho	ō	Md.	Ī	NA			altimo	re						X Yes 2
128e	Director	10e. Street and Numb					10f. Zip C	ode				10g. Citi	izen of What C	ountry?
23a o		2308 E.	. Chase	St.			21	.213				U	SA	
Department of needin and wested trypiene.  The man of the standard of the standard industry or items 23a or 28a-f ahow any injury or other traumatic evant, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status 1   Never Married 3   Widowed 4		12. Was Deceder Armed Forces 1  Yes 2 If Yes, Give Year or Dates	s? No		Was Deceder If Yes, specify 1 ☐ Yes 2√x		panic Oric , Mexican Specify:	gin? (Spec i, Puerto P	cify Yes or No Rican, etc.)	>-	14. Race - Am Black, Whi	
atura Cal E	edt		5. Decedent's I			16a. Dece	dent's Usual (	Occupat	tion			16b Kir	ind of Business	
Medii "n	Completed	(Specify Elementary/Second		rade completed) College (1-4o	r 5+)	(Give	kind of work DO NOT use	done du	uring most	of workin	ig .			a maddily
ar the	Com	12th grad		00,1098 (1 40	, 5 + ,	S	Sanitat	ion						
arked oth	To Be (	17. Father's Name (Fill Willie	irst, Middle, Las	st)	Spai	nn, Sı	r.	1			(First, Middle, erite	, Maiden	Sumame) Alsi	ton
is in management		19a. Informant's Nam	•				-						r Town, State,	
mm 27 ther t	1 3	Kenya Spail		Daugh			SUS W.		.berr		reet, B		more, 1	
or of		1 🖺 Burial 2 💢	Method of Disposition    20b. Place of Disposition (Name of cemetery, crematory or other place)   20c. Location - City or Town, State   4 Donation 5 Other (Specify)   Greenmount Cem.   4-29-05   Baltimore, Md.											
ntant	1	<ul><li>4 □ Donation 5</li><li>21. Signature of Fune</li></ul>		•	Gre		unt Cer 2. Name and /		of Engilib				Baltimon nore, Mo	
Impo any is		21. Signature of Puris	la la	o wan	)		March E						North A	
ledical aminer		disease or condition resulting in death)  Sequentially list condition	nal	b	as a conseque	ence of):	rdiova	of dying,	lar D	)isea:	se			Approximate Interval Betweer Onset and Death
cian and purial-transit	al Examiner		litions, ediate mg	b. Due to (or a	clerot	ence of):	rdiova	_	lar D	)isea:	se			Interval Between
gned by the attending physician and with the attending physician and be detached for use as the burial-transit to be detached for use as the burial-transit be detached for use as the burial-transit because the detached for use as the burial-transit because the detached for use as the burial-transit because the detached for use as the burial-transit because the detached for use as the burial-transit because the detached for use as the burial-transit because the detached for use as the burial-transit because the detached for use as the burial-transit because the detached for use as the burial-transit because the detached for use as the burial-transit because the detached for use as the burial-transit because the detached for use as the burial-transit because the detached for use as the burial-transit because the detached for use as the burial-transit because the detached for use as t	by Physiclan/Medical	Sequentially list condiff any, leading to immodule Cause (Disease or injustati initiated events	itions, ediate with the state of the state o	Due to (or a b.  Due to (or a c.  Due to (or a d.  23c. If yes, outcom	eclerot as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque	ence of): ence of): ence of): cy death 3 [ ath 5 [	⊒Ectopic pregi ] Other (speci	nancy		)isea:	23e. Did to	pbacco us		Interval Between Onset and Death Onset and Death Interval Between Onset and Death Onset and De
signed by the attending physician and dedetached for use as the burial-transit	by Physiclan/Medical	Sequentially list conditions, leading to immunity. Cause (Disease or injutati initiated events resulting in death) Lass  IF FEMALE: 23b. Was decedent print the past 12 mc 1  Yes 2 N 9 Unknown	itions, ediate with the state of the state o	Due to (or a b.  Due to (or a c.  Due to (or a d.  23c. If yes, outcom	eclerot as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque	ence of): ence of): ence of): cy death 3 [ ath 5 [	⊒Ectopic pregi ] Other (speci	nancy		)isea:		pbacco us	Month se contribute to	Interval Between Onset and Death Onset and Death Interval Between Onset and Death Onset and De
has been signed by the attending physician and the should be detached for use as the burial-transit to the state of the st	Completed by Physician/Medical	resulting in death)  Sequentially list conditions, leading to immunity cause (Disease or injuration in the past 12 mc in the past 12 mc 1 Yes 2 N 9 Unknown  Part II. Other significations	regnant onths?	Due to (or a b.  Due to (or a c.  Due to (or a d.  23c. If yes, outcom	eclerot as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque as a conseque	ence of): ence of): ence of): cy death 3 [ ath 5 [	⊒Ectopic pregi ] Other (speci	nancy ify)se given	ı in Part I.		23e. Did to 1 1 1	obacco us  (es 2)  an  an  ssy  rmed?  2 □ No	Month  se contribute to  No 3 pri  24b. Were at prior to death?	Interval Between Onset and Death  Silvery Pay Year  Day Year  Trobably 4 Unknown
certificate has been signed by the attending physician and rector, page 2 should be detached for use as the burial-transit	o Be Completed by Physiclan/Medical	resulting in death)  Sequentially list condificant, leading to immunity the condition of th	itions, ediate if it is	Due to (or a b.  Due to (or a c.  Due to (or a d.  23c. If yes, outcom 1 Live birth 4 Pregnant 9 Unknown contributing to death	is a consequence of pregnant 2   Fetal cat time of dea	ence of): ence of): ence of): cy death 3 cath 5 cath 5 cath 5 cath	⊒Ectopic pregi □ Other (speci nderlying caus	nancy ify)se given	n in Part I. 26. Place	of Death (	23e. Did to 1 1 4 24a. Was autop perfor 12 Yes (Check only o	obacco us  (es 2)  an  ssy  rmed? 2 □ No	Month se contribute to No 3 Pr 24b. Were au prior to death?	Interval Between Onset and Death Onset and Dea
After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-transit	To Be Completed by Physiclan/Medical	resulting in death)  Sequentially list conditions, leading to immunity. Cause (Disease or injuration injuration of the condit	itions, ediate if it is	Due to (or a b. Due to (or a c. Due to (or a d	sclerot as a conseque as a conseque as a conseque as a conseque as a conseque be of pregnance 2   Fetal c at time of dea	ence of): ence of): ence of): cy death 3 [ ath 5 [	□Ectopic pregi □ Other (speci nderlying cause	nancy ify)  Se given  Other: Injury a	n in Part I. 26. Place 	of Death of Sing Home	23e. Did to 1 1 4 24a. Was autop perfor 12 Yes (Check only o	obacco us  (es 2)  an  ssy  rmed? 2 \sum No  ne)  dence 6	Month se contribute to No 3 Pr 24b. Were au prior to death? 1 Ves	Interval Between Onset and Death Onset and Death
After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-transit	To Be Completed by Physiclan/Medical	resulting in death)  Sequentially list condition, leading to immunity. Cause (Disease or injust in intrated events resulting in death) Lass  IF FEMALE: 23b. Was decedent printhe past 12 mg 1 yes 2 Mg 1 Which was a miner?  25. Was case referred examiner?  12 Yes 2 No  27. Manner of Death  12 Natural  2 Accident	itions, ediate if if it is a second it is standard conditions. No ant conditions if it is a second it is a seco	Due to (or a b. Due to (or a c. Due to (or a d. d. Due to (or a d. d. Due to (or a d. d. Due to (or a d. d. Due to (or a d. d. Due to (or a d. d. Due to (or a d. d. Due to (or a d. d. d. d. d. d. d. d. d. d. d. d. d.	is a consequence of pregnant 2 Fetal cat time of deal but not result tient 2 E E E jury ay Year)	ence of):  ence of):  cy death 3 ath 5 ting in the unit in the uni	□Ectopic pregi □ Other (special nderlying cause nt 3□ DOA f □ 28c.	nancy ify)  Others Injury a Work? 1 □ Ye	o in Part I. 26. Place 3 4 □ Nur	of Death (rsing Hom 28	23e. Did to 1 \( \text{Yes} \) 24a. Was autoperfor perfor Yes (Check only o e 5 \( \text{Pesic} \) Bad. Describe h	obacco us  (es 2)  an  say  rmed? 2 \sum No  ne)  dence 6  now injury	Month se contribute to No 3 Pr 24b. Were at prior to death? 12 Yes 6 Other (Spe	Interval Between Onset and Death Onset and Death
After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-transit	Certification: To Be Completed by Physician/Medical	resulting in death)  Sequentially list condition, leading to immunity. Cause (Disease or injury)	ititions, tediate if it is a state of the medical o	Due to (or a b. Due to (or a c. Due to (or a d. d. Due to (or a d. d. Due to (or a d. d. Due to (or a d. d. Due to (or a d. d. Due to (or a d. d. Due to (or a d. d. Due to (or a d. d. d. d. d. d. d. d. d. d. d. d. d.	is a consequence of pregnant 2 Fetal cat time of deal but not result tient 2 Elipiury Pay Year) 2 Injury - At hometic. (Specify) 1 St of my knowl of examinatic	ence of):  ence of):  cy death 3 cath 5 cath	DEctopic pregion of the control of t	nancy ify)  Other: Injury a Work? 1 □ Ye	a in Part I.  26. Place  4 □ Nur  at  as 2 □ N	of Death raining Home	23e. Did to 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	obacco us  fes 25  an  ssy  rmed? 2 \sum No  ne)  dence 6  now injury	Month  se contribute to  No 3 Pr  24b. Were au prior to death? 12 Yes  G Other (Spe y occurred	Interval Between Onset and Death Onset and Death
wher this certificate has been signed by the attending physician and uneral director, page 2 should be detached for use as the burial-transit	To Be Completed by Physiclan/Medical	Sequentially list condition, leading to immunity. Cause (Disease or injuration in the past 12 mg 1	itions, ediate if it is a conditions st is it is a conditions in the conditions in t	Due to (or a b. Due to (or a c. Due to (or a d	is a consequence of pregnant 2 Fetal cat time of deal but not result tient 2 Elipiury Pay Year) 2 Injury - At hometic. (Specify) 1 St of my knowl of examinatic	ence of):  ence of):  cy death 3 cath 5 cath	Dectopic pregion of the state o	nancy ify)  Other: Injury a Work? 1 □ Ye	26. Place  4 □ Nur  at  as 2 □ N	of Death raining Home	23e. Did to 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	cause(s) date and	Month  se contribute to  No 3 Pr  24b. Were au prior to death? 12 Yes  G Other (Spe y occurred	Interval Between Onset and Death Onset and Death

Baltimore, Maryland 21215-0036 IOSIF SOLODUKHIN

		For State Registrar		Oldio Ol II	viarylaria		delible Ink. III artment of F tificate of			Reg. No.	2000	11.1
			e (First, Middle, Last)		_				2. Date of D	eath	— <del>U (J ∈</del> Vear	3. Time of Deaft
Physicia /Medic		IOSIF					SOLODI	JKHIN	APRIL	26 <sup>ay</sup>	200 <sup>5</sup> 5	8:10 A
Examin	er		f not institution, give s	treet and numbe	er)		4b. City, Town, o		th		ounty of Deat BALTIM	
Funeval		7616 UF 5. Social Security N	ARLA ROAD	7.7	Age (In yrs. las	t birthday)	If Under 1 Year	If Under 24 Hr	s. 8. Date of B			hplace (State or For
Funeral Director		218-43-6	5841 ¹\text{\text{\text{\text{7}}}	M 2□F	77	Yrs.	Months Days	Hours Min	8. Date of B (Month, D 03/15/	71928	Co	UKRAINE
Mo to		Usual Residence of 10a. State	10b. County		10c. City, 1	Town or Lo	cation					10d. Inside City Lin
e de la la la la la la la la la la la la la	tor	MD	BALTIMORE	<u>:</u>	ABL-	TIMOR	E- Ra	ltimore				1 ☐ Yes 2√
or 28e	Director	10e. Street and Nu	mber				10f. Zip Code	orthwise.		10g. Citize	on of What Co	untry?
23a unt b		7616 CARL					21208				S.A.	
f Health and Mental Hygiene. Item 27 is marked other then "natural", or Items 23a or 28e-f show other traumatic svent, the Modical Exporter must be notified at	by Funerai	<ul><li>11. Marital Status</li><li>1 ☐ Never Marr</li><li>3 ☐ Widowed</li></ul>	ied 2 🐧 Married	<ol> <li>Was Deceder Armed Force</li> <li>1 ☐ Yes 2 ☐</li> <li>If Yes, Give Year or Dates</li> </ol>	<b>∆</b> No		Was Decedent of H f Yes, specify Cuba 1 ☐ Yes 2 🗖 No	lispanic Origin? ( an, Mexican, Pue Specify:	Specify Yes or N rto Rican, etc.)		Black, White Becify:	
natur Isal	ted	(Spec	15. Decedent's Educ	ation		16a. Deced	dent's Usual Occup	ation	orkina	16b. Kind	f of Business/	Industry
giane. ir then "i	Completed	Elementary/Second 12		College (1-4c	or 5+)		kind of work done DO NOT use retired CHANT	1)	g	IN	DUSTRI	AL
d other svent, I	Be	17. Father's Name	(First, Middle, Last)						ame (First, Middle	e, Maiden S	umame)	
and Mental is marked o aumatic sve	ဥ	MAYER					DUKHIN	CLARA				KEILEN
raum			ame/Relationship <i>(Ty)</i>				ng Address (Street			•		Zip Code)
Health tem 27 i		20a. Method of Dis	OLODUKHIN ,	/ WIFE	20b. Plac	e of Dispo	CARLA RI sition (Name of	1	TIMORE,		ation - City or	Town, State
° = 5		1 🔀 Burial 2	☐Cremation 3 ☐Re  5 ☐Other (Specify)	emoval from Sta			natory`or other plac CONG.		28/2005	OWIN	GS MIL	LS. MD
Departmen Importent: any injury once.			ineral Bervice License	e ///	,,,,,,		. Name and Addre					
Depar impo any ir once.		MAN	the disease, or compliant failure. List only on	True	1/						VILLE,	MD 01000
Medical Medical xaminer	ai Examiner	Immediate Cause disease or conditic resulting in death)  Sequentially list co if any, leading to in cause. Enter Under Cause (Uisease or that initiated events resulting in death)	onditions, bonditions, mediate arriving injury s	Due to (or	as a consequer as a consequer as a consequer	nce of):	Cahe	e r				
ate has been signed by the attending physic page 2 should be detached for use as the b	Physician/Medic	IF FEMALE; 23b. Was deceden in the past 12 1 □ Yes 2	nt pregnant 2:	3c. If yes, outcom	2 Fetal de at time of dear	eath 3[	Ectopic pregnancy	′		23	d. Date of del Month	ivery Day Year
ed by the detached	Phys	9 Unknown							One Did	Jackson was	a a a material sustant a	the cause of death
signed d be de	þ	Part II. Other signi	ficant conditions con	tributing to death	/ Las L	_	nderlying cause gru	en in Part I.		Yes 2		obabiy 4 Unkn
been s	Completed				, , , ,							
s certificate has b irector, page 2 s	mpi					-			24a. Wa auto per	opsy formed?	prior to death?	topsy findings avail completion of cause
	e Co	25. Was case refer	rred to modical					OS Blace of D	1 ☐ Yes eath (Check only		1 ☐ Yes	2□ No
this certificatal director, I	o B	examiner?	/	ospital:	atient 2□EF	9/Outpatier	nt 3 DOA Ott				Other (Spe	cifv)
h. After this funeral o	J										S.177	
after dea Director I in by the	2 _ Accident										Number or Ru	ural Route Number,
within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical Co	29a. Certifier (Check only one)	1 Certifying Phys		s of examinatio							
within To the	Me	29b. Signature and	ved A	voit,	и,Р,		/ `	552		4	signed (Mont	jn .
				-			Print) Print) Print)					

DHMH 17 Rev 1/2001

ORIGINAL

			1 - For State Registrar	State of Mary	•	artment ertificate				Reg. No. 2 ()	105 14436
	Physici		Decedent's Name (First, Middle, Last)     FAYE			SOLOMO	N		2. Date of De Month	Day	Year 12/5 AM
	/Medic Examir		4a. Facility Name (If not institution, give s		UZNOTON			Location of D		4c. County	of Death
	Funeral		HEBREW HOME OF G  5. Social Security Number 6. Sex		HINGIUN yrs. last birthday	) If Under 1	Year	VILLE If Under 24		th	9. Birthplace (State or Foreign Country)
	Funeral Director		220-14-2403	M 257 F	80 Yrs.	Months	Days	Hours	Min. AUG. 2	1924	Country) MD
	fand ow		Usual Residence of Decedent  10a. State 10b. County	10	c. City, Town or I	ocation					10d. Inside City Limits
	e Mary ta-f sh	ctor	MD MONTG	OMERY	ROC	KVILLE					1 ☐ Yes 2 🙀 No
	with the or 28	<b>Funeral Director</b>	10e. Street and Number	NΓ		10f. Zip (	Code	2085	2	10g. Citizen of \	What Country? USA
	deeth me 23	erai	5957 VALERIAN LA	12. Was Decedent Ever	in U.S. 13	. Was Decede	ent of His		? (Specify Yes or No uerto Rican, etc.)	- 14. Rac	e - American Indian,
36	be filed within 72 hours after deeth with the Maryland tal Hygiene. dother then "natural", or iteme 23a or 28a-f show event, the Medical Examinar must be notified at	by Fur	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 🌠 No If Yes, G <u>i</u> ve		1 Yes, specif		Specify:	uerto Hican, etc.)	Specify	ck, White, etc.
21215-0036	2 hours atural'		3 Widowed 4 □ Divorced  15. Decedent's Educ	Year or Dates:	16a. Dec	edent's Usuaf	Occupat	tion		16b. Kind of Br	WHITE usiness/Industry
215	within 72 ene. then "na ina Wedla	Completed	(Specify only highest grade Etementary/Secondary (0-12) 12		life.	e kind of work DO NOT use	e retired)	iring most of	working		•
121	filed with Hygiene. Ither ther		17. Father's Name (First, Middle, Last)		BOC	KKEEPE		18 Mother's	Name (First, Middle,	FOOD	na)
Maryland		o Be	HARRY		WAR	TZMAN		ROS		, maidon dama.	ROSENBAUM
lary	d 2 should th and Men 7 Is marke traumatic	-	19a. Informant's Name/Relationship (Typ						r Rural Route Numb	·	
	teal teal m 2		STEVEN SOLOMON /		Ob. Place of Disc	osition (Name	e of		- ROCKVIL		20852 City or Town, State
mor	Pages ent of nt: If It		1 X Burial 2 ☐ Cremation 3 ☐ Re 14 ☐ Donation 5 ☐ Other (Specify)	emoval from State	cemetery, cr RADOMER	ematory or oth	her place		/28/2005	ROSEDA	
Baltimore,	permit. Pages : Department of H Important: If Ite any Injury or ot		21. Signature of Funeral Service License			22. Name and	Address	of Facility	SOL LEVIN	ISON & B	ROS., INC.
	20529		23a. Part1. Enter the disease, or complic	nations that caused the	death. Do not e						Approximate Interval Between
	/Medical Examiner	Examiner	shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a co	ensequence of):	- C	urcl	jo vas	oular	di sua	Onset and Death
8760,	ate be executed sysician and he burial-transit	ical Ex	resuming in death) cast	Due to (or as a co	nsequence of):						
9	tificate og phys as the									-17000-100	
P.O. Box	law requires that the death certificate as been signed by the attending phys 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	3c. If yes, outcome of p 1 □ Live birth 2 □ 4 □ Pregnant at time 9 □ Unknown	Fetal death 3	□Ectopic pre □ Other (spe					te of delivery onth Day Year
ecords, P.	w requires that is been signed by should be deta	by	Part II. Other significant conditions con	tributing to death but no	ot resulting in the	underlying car	use giver	n in Part I.		obacco use cont Yes 2 □ No	ribute to the cause of death?  3 Probably 4 Dinknown
$\alpha$	The ate ha	Completed							24a. Was autop pend 1 ☐ Yes	osy ermed?	Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No
Vital	Physician: Tribis certificateral director, pr	o Be	25. Was case referred to medical examiner?	ospital:	0[][[0]		Other		Death (Check only only of Besiden		(0%)
of	ing . After une	-	1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	1 ☐ Inpatient  28a. Date of Injury (Month, Day Ye	2 ER/Outpate 28b. Time ar) Injury	of 28	lc. Injury Work			how injury occur	
Division	tel or Attend s after death el Director: / ed in by the f	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Pface of Injury - building, etc. (S	At home, farm, s pecify)	treet, factory,	office		28f. Location (S City or Tox		er or Rural Route Number,
	To the Hospitel or At within 24 hours after of To the Funerel Direct completely filled in by	edical		sician: To the best of more: On the basis of exa and manner stated.	mination and/or	nvestigation, i	in my opi	nion, death	occurred at the time,	date and place,	and due to the cause(s)
	To the within To the comple	Σ	29b. Signature and title of certifier	11		29c.	License	number		29d. Date signed	d (Month, Day, Year)
•	9		30. Name and address of person who co	moleted cause of death	(Item 23a) /Tuni	Print)	4	490	7	April	25, 2005
ć	7		6121 Month	se Aug	c/	ROCK	-n1	de a	mp	208	25-2
E	Sta Registr		31. Date filed (Month, Day, Year) APR 2 8 2	32. Registrar's	Signature	Sparke					d (Month, Day, Year) - 25, 2005-

amend item#2,9,perMD, FH, G843,579/05 TT
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day **Physician** Dolliver L. 10:43 P M Swift 2005 25 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Glen Burnie North Arundel Hospital Anne Arundel If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day Year) 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Min. 468-28-8199 Hours 11XM 2□ F MN 74 Yrs. MIL Director Usual Residence of Decedent death with the Maryland show 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other then "neturel", or items 23a or 28a-f show other treumstic event, the Medical Examinations must be confilled at 1 ☐ Yes 2 XNo **Funeral Director** MD Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 414 Joyce Dr., SW 21061 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. Pages 1 end 2 should be filed within 72 hours after inent of Health and Mental Hygiene. int: If item 27 Is marked other then "neturel", or Ite 1 ☐ Never Married 2 X Married XYes 2 ☐ No f Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify: Be Completed by Specify white 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Analyst Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Clara Leppla ဂ္ Edward Swift 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Jeannine Swift / wife 414 Joyce Dr. SW, Glen Burnie MD 21061 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 'Department of H Important: If ite any injury or ot once. 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4/29/05 Stevensville, MD Chesapeake Cremation 1 4 ☐ Donation-5 Other (Specify) 21. Signature of unital service 22. Name and Address of Facility Singleton Funeral Home P.A. 1 Second Ave SW Glen Burnie MD 21061 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysician myocandia MIN 58 disease or condition resulting in death) /Medical Oue to ( s a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner The law requires that the death certificate be executed ding physicien and se as the burial-transit resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 ☐Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year Month 4☐Pregnant at time of death signed by the a d be detached for 5 Other (specify) 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 200 No Chale Neh 1 🗌 Yes 1 ☐ Yes To the Hospitel or Attending Physicien: 25. Was ca r ferred to medical examine.2 Be 26. Place of Death (Check only one Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 2 ER/Outpatient 3 DOA this : After this funeral of 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Certification: Injury at Work? 28d. Describe how injury occurred Injury 5 Pending investigation М 1 ☐ Yes 2 ☐ No death 2 Accident the Director 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 \( \text{Homicide} \) within 24 hours a To the Funerel I 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) A21613 9 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Loraine M. Dailey, M.D. 8096 Edwin Raynor Blvd., Pasadena, Maryland 21122 egistrar's Signature 31. Date filed (Month, Day, Year) APR 28 State 2005

Registrar

		101	artment of Health and Mental Hygic ertificate of Death	ene 
Physic		1. Decedent's Name (First, Middle, Last) Paul Otto Smith Sr.	2. Date of Death Month	
/Med Exam		4a. Facility Name (If not institution, give street and number)  North Arundel Hospital	4b. City, Town, or Location of Death Glen Burnie	4c. County of Death Anne Anudel
Funera Directo		5. Social Security Number 217-24-1115 6. Sex 1 M 2 F 76 Yrs.	If Under 1 Year   If Under 24 Hrs.   8. Date of Birth (Month, Day)   Hours   Min.   3-2-1929	9. Birthplace (State or Foreign Country) MD
Maryland f show	Jo	Usual Residence of Decedent  10a. State		10d. Inside City Limits 1 ☐ Yes 2 ☒ No
with the la or 28a-	Direct	10e. Street and Number 106 Chalmers Ave.	10f. Zip Code 10g	g. Citizen of What Country?  USA
Baltimore, Maryland 21215-0036 permit. Pages 1 end 2 should be flied within 72 hours after death with the Maryland Department of Heelth and Mental Hygiene. Important: if Item 27 is marked other than "natural; or items 23a or 28a-1 show any injury or other traumatic event, the Medical Exeminer must be notified at	by Funeral Director	11. Marital Status  1 Never Married 2 Married  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces?  W Yes 2 No If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  1 Yes 2 No Specify:	14. Race - American Indian, Black, White, etc.  Specify: white
Maryland 21215-0036 to 2 should be flied with 72 hours aft th and Mental Hygiene. It is marked other than "natural", or traumatic event, the Medical Exemitations.	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+) 2  Lith	edent's Usual Occupation a kind of work done during most of working DO NOT use retired) acgrapher	6b. Kind of Business/Industry Printing
vid be filed Mental Hygarked otherstic event,	To Be C	17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Ma Elva Rush	aiden Sumame)
Mary,		19a. Informant's Name/Relationship (Type, Print)  Mrs. Helen M. Smith/wife  106	ing Address (Street and Number or Rural Route Number, Chalmers Ave., Glen Burnie	
Baltimore, sernit. Pages 1 er Department of Hee mportant: if Item into injury or other		4 Donation 5 Other (Specify) Glen Have	n Cemetery 4/30/05 G	Oc. Location - City or Town, State
Balt permit. Depart Imports any inji			2. Name and Address of Facility Singleton F Second Ave SW Glen Burnie	
Physiciar /Medica Examine		23a. Part 1. Enter the disease, or complications that caused the death. Do not er shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):	ter the mode of dying, such as cardiac or respiratory arres	st, Approximate Interval Between Onset and Death
rate be executed physicien and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to unmediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):		
Box 6 death certifi e attending for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 4 □ Pregnant at time of death 5 9 □ Unknown	□Ectopic pregnancy □ Other (specify)	23d. Date of delivery Month Day Year
cords, P.O. w requires that the should be detached by the	b	Tarri. Date: Significant conditions contributing to death but not resulting in the	underlying cause given in Part I. 23e. Did toba 1 ☐ Yes	cco use contribute to the cause of death?
FRe ia	Completed		24a. Was an autopsy performs	24b. Were autopsy findings available prior to completion of cause of death? 2No 1 \( \text{Yes} \) 2\( \text{No} \)
vision of Vital F Attending Physicism: Th r death. setor: After this certificete by the funeral director, pag	To Be	25. Was case referred to medical examiner?  1 ☐ Yes 275 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpaties		ice 6 Other (Specify)
Division al or Attending safter death. I Director: After d in by the fune	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	treet, factory, office 28f. Location (Stre City or Town,	pet and Number or Rural Route Number, State)
Division  To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medical C	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, dea 2 Medical Examiner: On the basis of examination and/or in and manner stated.	th occurred at the time, date and place, and due to the cau nvestigation, in my opinion, death occurred at the time, dat	use(s) and manner as stated. e and place, and due to the cause(s)
To the training of training of the training of the training of the training of trainin	×	29b. Signature and URV of certifier	29c. License pumber 29c	Date signed (Month, Day, Year)
10	1	30. Narbe and address of person who completed cause of death (Item 23a) (Type	Print) Her old Dive R.	100 125 2005 ROBINGER
S Regis	tate trar	3)-Date filed (Many Rey Year) 2005 Registrar's Signature	25 1 4 0 D 1 1 4 0 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	JONNIA ((VA)

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

			For Stete Registrar	State of	f Marylai		artment of Herificate of L		Mental Hy	00.	Δ r=	11100
			Registrar  1. Decedent's Name (First, Middle, I	ast)	<del></del>	Ce	Tuncate of L	Jeani	2. Date of De	Reg. No.		3. Time of Death
н	Physicia		Stanle		9	zeliga			Month AFR	Day	Year 2005	
	/Medic Examin		4a. Facility Name (If not institution, g			zerrgu	4b. City, Town, or	Location of Dea		4c. County		
	Exami	Ģ.	Saint Joseph	Medica	al Cer	ter		Tow		}	Balt	imore
	Funeral Director		215-28-7778	Sex 1XM 2□F	7. Age (In yrs		If Under 1 Year Months Days	If Under 24 Hr Hours Mir	n. (Month. Da	3,1930	9. Birth Cou Mc	pplace (State or Foreign intry) aryland
	and w	}	Usual Residence of Decedent  10a. State 10b. County		10c. C	ity, Town or Lo	ocation					10d. Inside City Limits
	f sho	ō	Maryland Baltin	0000		Balt <sup>.</sup>						1 ☐ Yes 2 No
	28a-	Director	10e. Street and Number	101 6		Daic	10f. Zip Code			10g. Citizen of	What Cor	untry?
	h with		611 Stevenson	Lane			21286			U.	S.A.	
	deat	Funerai	11. Marital Status	12. Was Dece Armed Fo		J.S. 13.	Was Decedent of Hi	spanic Origin?	(Specify Yes or No	o- 14. Ra		ican Indian,
21215-0036	d within 72 hours after death with the Maryland Jiene. r than "natural", or Itams 23a or 28a-f show The Madical Examinat number natilised at	Ď	1 ☐ Never Married 2 💢 Married 3 ☐ Widowed 4 ☐ Divorced	1 XYes If Yes, Giv Year or D	²□⋈Kor	ea	1 ☐ Yes 2 No	Specify:	nto rucan, etc.,	Specia	fv-	nite
2-0	72 hc	Completed	15. Decedent's (Specify only highest	Education grade completed)		(Give	dent's Usual Occupa	luring most of w	rorking	16b. Kind of B	Jusiness/I	ndustry
121	within ene. than "	m	Elementary/Secondary (0-12)	College (1	-4or 5+)		DO NOT use retired,			77	4 (	
2	F F F		17. Father's Name (First, Middle, La	st)		Manage	er of Comp		oerations ame (First, Middle			ompany
an	0 # D 0	To Be	George Sa	eliga				Mari	e Ri	alek		
Maryland	ds but man		19a. Informant's Name/Relationship			19b. Maili	ng Address (Street a				, State, Z	ip Code)
	1 and 2 Health a em 27 is thar tra		Betty Ann Szelic	ga Wi	fe	611 9	Stevenson	Lane	Baltimor	e, Mary	land	21286
ore	S = S		20a. Method of Disposition 1 ☐ Burial 2 【X Cremation 3	□ Bemoval from		Place of Dispo cemetery, cre	osition (Name of matory or other place	9)	Date	20c. Location	- City or T	Town, State
Ë	Pages ment of I ant: If it		4 □Donation 5 □ Other (Spe	cify)	Hi		Service Co		29-2005	Towson	Ma	aryland
Baltimore,	permit. Page Department of Important: If any injury or once.		21. Sign wre of tune at Service file	Rfam			2. Name and Addres LO50 York	L,	Ruck Tows Towson,			łome, Inc. 21204
			23a. Part1. Enter the disease, or co shock, or heart failure. List or	omplications that cally one cause on e	aused the dea	th. Do not en	ter the mode of dying	g, such as cardi	ac or respiratory a	irrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	a PUL	MONAR	Y EMBO	DLISM					Onset and Death 24 HOURS
	/Medical Examiner		resulting in death)	Due to	or as a conse	quence of):						4 110110
		e.	Sequentially list conditions,	D	PIRATI		AILURE					1 HOUR
	ted nsit	nine	cause. Enter Underlying Cause (Disease or injury									
<u>,</u>	axecu n and al-tra	Examin	that initiated events resulting in death) Last		or as a conse							
68760,	ficate be executed physician and is the burial-transit	dicail		d								
68	rtifical ng phy as th		IS SELVAL S.									
Вох	death certific e attending p ad for use as	an/h	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, out 1□Live b	come of pregration in the come of pregration in the come of pregration and come of the com		□Ectopic pregnancy				ate of delive	very Day Year
.O.	0 0 0	Physician/M	1 Yes 2 No	4□Pregr 9□ Unkn	ant at time of own	death 5[	Other (specify)			,,,,	OCT.	Buy Tour
<u> </u>	The law requires that the ate has been signed by th page 2 should be detache		Part II. Other significant condition	s contributing to de	eath but not re	sulting in the i	ınderiving cause give	en in Part I.	23e. Did	tobacco use con	tribute to	the cause of death?
ds,	uires sign	d by	CHRONIC OBSTRUCT	IVE PULMO	ONARY I	ISEASE	SEDENTAR	v	1 🗆	Yes 2 □ No	3V Pro	babiy 4 Unknown
COL	w requ	lete							24a. Was	an 24b.	Were aut	topsy findings available
Record	The lay	Completed								ormed?	death?	ompletion of cause of 2 No
Vital		0	25. Was case referred to medical	4				26. Place of D	1 ☐ Yes eath (Check only	one)	1 🗆 Yes	24 110
<u>&gt;</u>	Q	To B	examiner? 1 □ Yes 2 X No	Hospital: 1 🔲	Inpatient 2	ER/Outpatie	nt 3 DOA Othe	ar: 4 🗆 Nursing	Home 5 ☐ Res	idence 6 Ot	her (Spec	ity)
n of			27. Manner of Death  1 Natural 5 Pending	28a. Date (Mon	of Injury th, Day Year)	28b. Time of Injury	of 28c. Injury Work	at c?	28d. Describe	how injury occu	rred	
sio	ttandi death. ctor: A / the fu	cati	2 Accident investiga 3 Suicide 6 Could no	t he	4.1			Yes 2 □No	00/ 1	(0)		
Division	il or Attand after death   Director: ,	Certification;	4 Homicide determin	ad 200. Flace	of Injury - At ing, etc. (Spec		reet, factory, office			(Street and Num wn, State)	ber or Hui	ral Route Number,
_	ours sours a laral filled		29a. Certifier 1X Certifying	Physicien: To the	best of my kr	nowledge dea	th occurred at the tim	ne date and pla	ce, and due to the	cause(s) and m	anner as	stated
	To the Hospitel or Attending within 24 hours after death. To the Funeral Director: Attencompletely filled in by the fune	Medical	(Check only 2 Medical Exone)	reminer: On the b	asis of examir ner stated.	ation and/or in	nvestigation, in my op	pinion, death oc	curred at the time	, date and place,	and due	to the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier				29c. License	number		29d. Date signe	ed (Month	, Day, Year)
	11	1	april P. Ci	exun	from H	.ρ.	e a	39215		4/27/	200	5
1	(X)/	1	30. Name and address of person w	no completed c	se of death (Ite	em 23a) (Type	, Print)					
1	11		- GAIL CUNNING	HAM M. I	76.2 ogistrar's Sign	4 OSL	ER DRIVE	TOWS	ON MARY	AND 2	1204	
A. 15"	Sta Regist	ate rar	APR 2 8	2005	logistrar's Sign		Cartes					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Spencer April 6:25PM D. 26, 2005 /Medical 4b. City. Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Middle River Baltimore Ivy Hall Geriatric & Rehab Center If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) April 22, 1926 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Min. 1 □ M 20 F Months 79 217-20-8581 MD. Director Usual Residence of Decedent with the Maryland 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumatic event, the Medical Examiner must be notified at Essex 1 ☐ Yes 2 No MD. Baltimore Director 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code USA Items 23a 702 Clover Avenue 21221 Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 2 should be filed within 72 hours after on and Mental Hygiene. 1 ☐ Yes 2 💢 If Yes, Give Year or Dates: 1 Never Married 2 Married 2 X No 1 ☐ Yes 2X No Specify: Specify: White 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b, Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 years Secretary Social Security 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Emma Campbell Charles Kenney 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 Is rr any injury or other traum once. 702 Clover Avenue, Essex, MD. 21221 daughter Linda Spencer 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State April 30, 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Gardens Of Faith Cem. 4 ☐ Donation 5 ☐ Other (Specify) 2005 Rosedale, Md. 21. Signature of Fine al Service License 22. Name and Address of Facility
Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Md. 21222 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Physician/Medical Examiner Cause (Disease or injury that initiated events resulting in death) Last as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): IF FEMALE: use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Year jo Day 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a detached f 9 Unknown signed by details 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 0 mentia 1 Yes 2 No 3 Probably 4 Hhknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an page 2 s. autopsy performed? 1 ☐ Yes 2 1 No certificate 25. Was case referred to medical examiner? 26. Place of Death (Check only one) director Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No P 1 Inpatient 2 ER/Outpatient 3 DOA this After this funeral of 28b. Time of Injury 27. Manner of Death Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending 1 🗀 Yes 2 🗌 No death. investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Box 68760. P.O. Records, Division of Vital the Hospital or Attending Physician: Director: within 24 hours after common to the Funeral Director 0

Baltimore, Maryland 21215-0036

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) 29b. Signature and title of certifier

and manner stated

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 709. B NASERM. MALIKA

State Registrar

Medical

31. Date filed (Month, Day, Year)

32. Registrar's Signature



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend item 18 per fh 9842 4-28-05 vt. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No... 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician 14:00M Vastina /Medical Stoakley 5 4 1 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner HONES EALTH WARE SAINI ALTIMORE Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1 ☐ M 2 💢 F Yrs. Director 220-30-5452 09/28/1911 Maryland Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show Pages 1 and 2 should be filed within 72 hours after death with the Maryla nent of Heatith and Mental Hygiene.
ant: If item 27 is marked other than "natural", or Items 23c or 28a-f show ury or other traumatic event, the Medical Examinat must be multived at 1 TYes 2 □ No Baltimore Directo Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 442 Whatty Court 21201 Funeral U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 27 No Specify: Black Specify: þ 3 Widowed 4 ☐ Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Homemaker 12 Housewife 18. Mother's Name (First, Middle, Maiden Symame)

Carrie Seneca Underdew

Ethel Underdoo 17. Father's Name (First, Middle, Last) Be Nelson Henson ပ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 is any injury or other trau once. Mazie Watkins / Daughter 748 Dr. Benjamin Quarles Place, Baltimore, Md. 21201 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐8urial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) 04/29/2005 New Cathedral Ceme. Baltimore, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility The Derrick C. Jones F/H, P.A. 4611 Park Hgts. Ave., Baltimore, Maryland 21215 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) MYOCASOGIA Physician UNTUBUR /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autonsy perform 1 ☐ Yes 2 ☐ No 1 Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other} \( \text{(Specify)} \) 2 ER/Outpatient 3 DOA 2 1 Tes 28b. Time of Injury 27. Manner of Jeath
Natural
Accident 28a. Date of Injury (Month, Day 28c. injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after d To the Funeral Direct completely filled in by 1 filled in by 4 🗌 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2005 D47353 on who completed cause of death (Item 23a) (Type, Print) 30. Name and ss of per Baltmore, 900 Caton Avenue MICK MD JON APR 2 8 State 2005 Registrar

			1- For State of Maryland / Department / Department / Depar	artment of Health and Mertificate of Death		ne . No. 2 0 0 5	11.1.1.2
	_		Decedent's Name (First, Middle, Last)		2. Date of Death	_	3. Time of Death
	Physicia /Medic		LILLIAN	SEAMAN A	APRIL 2	21 2005	3:36 P M
	Examin	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	-
	Euparal		3415 JANELLEN DRIVE 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	BALTIMORE If Under 1 Year If Under 24 Hrs.	8. Date of Birth	BALTIMORI 9. Birth	place (State or Foreign
	Funeral Director		488-03-4758 1□ M 2√ F 89 Yrs.	Months Days Hours Min.	APR. 4,19	16 Coul	MO MO
	w		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Lo	cation			10d. Inside City Limits
	Maryi -f sho	to	MD BALTIMORE BALT	IMORE			1 ☐ Yes 2 ☑ No
	th the	Director	10e. Street and Number	10f. Zip Code	10g	. Citizen of What Cou	ntry?
	ath wil	ralD	3415 JANELLEN DRIVE	21208			USA
920	72 hours after death with the Maryland "natural", or Items 23a or 28e-f show odical Examiner must be rediffed at	by Funeral	Armed Forces? I	Was Decedent of Hispanic Origin? (Specif Yes, specify Cuban, Mexican, Puerto F  □ Yes 2 \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	cify Yes or No- Rican, etc.)	14. Race - Americ Black, White, Specify:	
5-0	72 ho	eted	(Specify only highest grade completed) (Give	dent's Usual Occupation kind of work done during most of workin	ng 16	b. Kind of Business/In	dustry
21215-0036	withir ane. than	Completed	Flementary/Secondary (0-12)   College (1-4or 5+)	DO NOT use retired) MAKER	0	WN HOME	
2	Hyge Hyge	a l	17. Father's Name (First, Middle, Last)	18. Mother's Name			
/lan	Q 22 D .	To B	MAX SILV	'ERBERG LEAH	ZE	MEL	
Maryland		i		ng Address ( <i>Street and Number or Rural</i> GREENWICH PLACE - B			
	s 1 and 2 f Health item 27 I			the same of the sa	-	c. Location - City or To	
m o	Pages nent of l ant: If its ury or o		1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)	usition (Name of pace) SOCIETY  WOLINER BENEV. 4/	26/2005	BALTIMOR	E, MD
Baltimore,	permit. Pages Department of Important: If it any injury or o		21. Signature of Funeral Service Licensee 22	2. Name and Address of Facility SOL	LEVINSO	N & BROS.,	INC.
			23a. Part1. Enter the disease, or complications that caused the death. Do not ent shock, or heart failure. List only one cause on each line.				Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)	SCUP			Onset and Death
	/Medical Examiner		Due to (or as a consequence of):				5.5
Ļ		Jer	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):				
V	ocuted nd transit	Examin	cause. Enter Underlying Cause. Company Company (hat initiated events				
60,	cate be executed physician and the burial-transit	al Ex	resulting in death) Last Due to (or as a consequence of):				
68760,	phy:	edical	d				
O. Box	he death certifii the attending p	Physician/Me		Ectopic pregnancy Other (specify)		23d. Date of delive Month	ery Day Year
s, P.	es that lhe de gned by the a be detached f	by Ph	Part II. Dther significant conditions contributing to death but not resulting in the u	nderlying cause given in Part I.	23e. Did tobac	cco use contribute to t	he cause of death?
ords	w requires been sign should be		HBP, Thorand Forth In	mexim	1 ☐ Yes	2 10 3 Prot	oably 4 Unknown
1 Record	The lay	Completed			24a. Was an autopsy performe	d? prior to co	opsy findings available impletion of cause of
Vital	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?  Hospital:	26. Place of Death			_
of		To To	27. Manner of Death 28a. Date of Injury 28b. Time o		ne 5 🔼 Residence 8d. Describe how		(y)
ion	ttending Ph death. ctor: After th the funeral	ation	1 Natural 5 Pending (Month, Day Year) Injury 2 Accident investigation	Work? M 1 ☐ Yes 2 ☐ No			
Division	for Attending after death. Director: After in by the fune	Certification	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, ste building, etc. (Specify)	reet, factory, office 2	8f. Location (Stree City or Town, S	et and Number or Rura State)	al Route Number,
	To the Hospital or A within 24 hours after To the Funeral Direct completely filled in by	Medical Ce	29a. Certifier  (Check only one)  1 Certifying Physician: To the best of my knowledge, deat and manner stated.	h occurred at the time, date and place, a vestigation, in my opinion, death occurre	nd due to the caused at the time, date	se(s) and manner as s a and place, and due to	stated. o the cause(s)
	To the within To the	Me	29b. Signature and title of Certifier	29c. License number	29d	. Date signed (Month,	Day, Year)
	_		Imulit hill mo	016441		4/72/0	25
	6		30. Name and address of person who completed cause of death (Item 23a) (Type, 21 Crops odds Nr O41nb M		117		
	Sta Regist		31. Date filed (Month, Day, Year) APR 2 8 2005  32. Figistrar's Signature	hade	·		

TIME LIMITE SCHEAF Unknown Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 05-02773 State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra crn Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** <u>April</u> 20 2005 Tina M. Scheve /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Interstate 695 near Belair Road Parkville Baltimore If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplece (State or Foreign Country) 5. Social Security Number **Funeral** 1 ☐ M 2 🗷 F 215-80-2801 Yrs. Director 11/19/67 Maryland Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 28a-f shov 1 ☐ Yes 2 No Director f Health and Mental Hygiene. Item 27 Is marked other then "natural", or Items 23e or 28a-f other traumatic event, It e Madical Examiner must be ricilla Overlea Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21236 4507 Fullerton Ave. USA death Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 2 should be filed within 72 hours after and Mental Hygiene. Is marked other then "natural, or Itel I □Yes 2 No 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗷 No Specify: þ If Yes, Give Specify. 3 Widowed 4 Divorced Year or Dates: White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 0 <u>Dental Assistant</u> Dental 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ပ EDward Scheve, Sr. Helen Kaniecki Pages 1 and 2 should 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If Item 27 Is any injury or other trat <u>once.</u> Mrs. Helen Dylewski 3471 Dunhaven Rd. Baltimore, Md. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Holy Rosary Ceme. 4/26/05 Dundalk, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Kaczorowski Funeral Home P.A. Dundalk Ave. Baltimore, Md. 21222 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician THERMAL SHOKE INHALATION AND KEAD /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consuluence of) Physician/Medical Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy Month in the past 12 months? Day Year Pregnant at time of death 5 Other (specify) P.0. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 △ Yes 2 □ No 24a. Was an autopsy performed? 12 Yes 2 □ No the Hospital or Attending Physicien: 25. Was case referred to medical 26. Place of Death (Check only one) examiner' at scene Other: 4 Nursing Home 5 Residence 6 HOther (Specify) Certification: To 1XYes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Division of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Injury 1 Natural 5 Pending DRIVER OF LAR IN COLLISION 4:21 P 1 ☐ Yes 2 X No death. 4/20/05 2 Accident investigation within 24 hours after deat To the Funeral Director: completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1-695 NEAR BELAIR RD, MP 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2X Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

State

Registrar

29c. License number

111 Penn Street

29d. Date signed (Month, Day, Year)

Baltimore, Maryland 21201

OCME April 21, 2005

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

RUBIO, MD ANA

31. Date filed (Month, Day, Year) APR 2 8 2005

29b. Signature and title of certifier

32. Redistrar's Signature

J			_ FOI	Department of Health and Mental Hyg  Certificate of Death	iene eg. No. 005   4444
	Physicia /Medic	an al	1. Decedent's Name (First, Middle, Last)  An High James (If not institution give street and number)	2. Date of Deat Month APRII.  4b. City, Town, or Location of Death	h Day Yeer 18, 2005 5:50P. M
	Examin	er	309 WHITRIDGE AVE  5. Social Security Number  6. Sex  7. Age (In yrs. last bin	BALTIMORE  If Under 1 Year   Hunder 24 Hrs. 8. Date of Birth  Additional Plant   Hunder 24 Hrs. 8. Date of Birth  Only 1 Hunder 1	9. Birtholage (State or Foreign
	Director show	J.	Usual Residence of Decedent  10a. State  10b. County  10c. City, Town	n or Location	10d. Inside City Limits
	urs after death with the Marylar al', or Itama 23a or 28a-f show Examinet must be notified at	Funeral Director	10e. Street and Number  309 Whitrids p Averve	1 th m are	0g. Citizen of What Country?
920	ours after dea al', or Itama Exactiner ma	þ	11. Marital Status  1 Vever Married 2 Married 3 Widowed 4 Divorced  72. Was Decedent Ever in U.S. Armed Forces?  1 Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.)  1 ☐ Yes 2 ☐ No Specify:	14. Race - American Indian, Black, White, etc.  Specify: Black
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Itam 27 is marked other then "natural", or Itams 23e or 28e-1 show any injury or other traumatic event, I've Medical Exactinet must be notified at once.	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)	Decedent's Usuat Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry  ROOPing
Maryland	should be filed and Mental Hyge marked oths umarked ownt,	To Be C	17. Father's Name (First, Middle, Last)  Charle (Father's Name/Relationship (Toe, Print) 19b	18. Mother's Name (First, Middle, MEHG V, T  Mailing Address (Street and Number or Rural Route Number.)	ay/00
	ges 1 and 2 s t of Health an If Itam 27 is or other trau		Done tha J. Williams / Srsten 1 20a Method of Disposition 20b. Place of	318 N. Stockton St. &	20c. Location - City or Town, State
Baltimore,	permit. Pag Department Important: any injury once.		* 4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service Licensee	ew (rom duy 14/28/05  22. Name and Address & Facility Close For 512/0 3 Plana Proc	Balt More P.A.
	Pnysician /Medical			TIC CORDIO MSCUME DI	Approximate Interval Between Onset and Death
	Examiner	Iner	Sequentially list conditions, b. Due to (or as a consequence cause. Enter Underlying Cause, (Disease or injury)		
8760, ~	cate be executed physicien and the burial-transit	dical Examiner	that initiated events resulting in death) Last  c. Due to (or as a consequence d.	of):	
Box 6	Attending Physiclan: The law requires that the death certifics rdeath. ector: After this certificate has been signed by the attending pt by the funeral director, page 2 should be detached for use as t	Completed by Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  23c. tf yes, outcome of pregnancy 1 □ Live birth 2 □ Fetat death 4 □ Pregnant at time of death 9 □ Unknown	3 Ectopic pregnancy 5 Other (specify)	23d. Date of delivery Month Day Year
, rds, P.O.	equires that the signed by ould be detact	ted by Phy	Part II. Other significant conditions contributing to death but not resulting in		pacco use contribute to the cause of death?  as 2 □ No 3 □ Probably 4 ☑ Unknown
, ' Division of Vital Records,	in: The law r ificate has be or, page 2 sh		25. Was case referred to medicat	24a. Was a autops perform 1 XX es 2	prior to completion of cause of death?  2 No 1 Yes 2 No
f Vi	nysicle iis cert direct	To Be	examiner?  1XXYes 2 No  Hospital: 1 tnpatient 2 ER/Ou	Other	ence 6 XOther (Specify) SCENE
0 0	ing Pt	on:	1 ☑Natural 5 ☐ Pending (Month, Day Year)	njury Work?	ow injury occurred
Divisio	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funaral Director: After this certificate has completely filled in by the funeral director, page 2	Certification;	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, ta building, etc. (Specify)	M 1 ☐ Yes 2 ☐ No  irm, street, tactory, office 28f. Location (St. City or Town	reet and Number or Rural Route Number, n, State)
	the Hospit hin 24 hour the Funara	Medical	(Check only one) 2 M Medical Examiner: On the basis of examination an and manner stated.	a, death occurred at the time, date and place, and due to the codor investigation, in my opinion, death occurred at the time, d	ate and place, and due to the cause(s)
	viti To		29b. Signature and title of certifier	OCME A	9d. Date signed (Month, Day, Year) PRIL 19,2005
	3		30. Name and address of person who completed cause of death (Item 23a)  AMA  RUB IO  Balance And Amazer And Amazer And Amazer And Amazer And Amazer Andrew A	(Type, Print)  111 Penn Street Balti	more, Maryland 21201
	Sta Regist			Link	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item 19a per inf 9843 5-9-05 vt.

State of Maryland / Department of Health and Mental Hygiene

			1 - State Registrar		,	Ce	rtificate	e of L	Death	1		Reg. No.	2005	141	+45
	Physicia	n	1. Decedent's Name (First, Mi	iddle, Last)							2. Date of De Month	eath Day	/ Year	3. Time of E	Death
	/Medic		Marion			Tayl					4	23	2005	8:15p	) M
	Examin	er	4a. Facility Name (If not institu Heritage Cer	ution, give street and numbe nter Genesis	r)			Town, or unda	Location 1k	of Death		4c.	County of Dear Balt:		
	Funeral Director		5. Social Security Number 212–42–3841	6. Sex 1 ☐ M 2 X F	Age (In yrs. last 62	birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	Min.	8. Date of Bi (Month, Di 10-1	rth ay, Year) 2-42	9. Birt Co	hplace (State or untry)	Foreign
	and *		Usual Residence of Decedent 10a, State 10b, Cou		10c. City, To	own or Lo	ocation							10d. Inside City	v Limits
	Maryll f sho	Į.	Md.	NA	,	altir								12 Yes	
	r 28e	Director	10e. Street and Number				10f. Zip	Code				10g. Citi	zen of What Co	untry?	<del></del>
	th with	ai D	1201 Broeni	.ng Highway				2122	24				USA		
	ar dea	Funerai	11. Marital Status	12. Was Deceder Armed Forces	s?	13.	Was Deced	lent of Hi	spanic Or n, Mexica	igin? (Spe n, Puerto I	cify Yes or N Rican, etc.)	0-	14. Race - Ame Black, Whit		
900	be filed within 72 hours after death with the Maryland ital Hygiene. Ind other than "natural", or Itama 23a or 28e-f show evant, the Madical Exstrictor must be notified at	by	1 Never Married 2 1 3 Widowed 4 Divor	If Yes Give			1 ☐ Yes	2⊠ No	Specify	:				lack	
5-0	72 h "natu	etec	15. Dece (Specify only hig	dent's Education ghest grade completed)	16	(Give	dent's Usua kind of wor	k done a	turina mos	st of workir	ng	16b. Ki	nd of Business/	Industry	
121	within ene. than *	Completed	Elementary/Secondary (0-1 12th grade	2) College (1-4o	r 5+)		DO NOT us il Sor		)			II C	. Post	Office	
<b>d</b> 2	filed Hygid other ant,	Be Co	17. Father's Name (First, Midd	dle, Last)		ria.	11 501	CEL	18. Moth	er's Name	(First, Middle			OLLICE	
ılan	2 should be filed withir and Mental Hygiene. is marked other than aumatic evant, It's M	To B	Arthur		Green,	Sr.			M	larior	n u	nK.			
Maryland 21215-0036	s 1 and 2 should f Health and Men itam 27 is marke other traumatic		19a. Informant's <b>Remnet</b> Latoya <del>Taylor</del>								Route Numb		r Town, State, 2	Tip Code) 21224	
Baltimore,	ges 1 and 1 of Health if itam 27 or other tr		20a. Method of Disposition	• ES	romo	of Dispo	osition (Nam	ne of ther place	9)	D	ate	20c. Lo	cation - City or	Town, State	
ij	parmit. Pages Department of i Important: if its any injury or o		'4 Donation 5 Dothe	on 3 □Removal from Stat r <i>(Specify)</i>	(8)		l Mem.		′ 1	4-28	8-05	Du	ndalk,	Md.	
3alt	parmit. Pag Department important: i any injury o		21. Signature of Funeral Serv	ice Licensee		2:	2. Name an	d Addres	s of Facili	ity	Balti			21202	
	00 = « O	-	230 Part Enter the disease	ling wan	اللق		March						orth Ave		
			23a. Part1. Enter the disease shock, or heart failure. Immediate Cause (Final	List only one cause on each	line.	O not en	ter the mode	e or ayıng	g, such as	cardiac of	r respiratory a	arrest,		Approximate Interval Betwo	een
	Physician /Medical		disease or condition resulting in death)	a. ACV	as a consequence	Kr.	-11/1		1 1	111	UKL	_		ODA	12
	Examiner			MÜ	LTIP	LE	- M	ME	= 15	MG	A			7 MON	THS
	<b>/</b> □ =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or a	as a consequenc	ce of):		- ( -			- ,				
V	and -trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c	as a consequenc	20.00									
68760,	The faw requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit			200 10 (01 8	as a consequent	Je 01).									
687	ificate g phys as the	Medical		d											
Вох	attendin		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom	ne of pregnancy 2  Fetal dea	ath 3.	∃Ectopic pre	adnancy				2	23d. Date of del		
	e deat he att	Physician	in the past 12 months? 1  Yes 2 No		at time of death		Other (sp						Month	Day Ye	ear
P.0	uires that the de signed by the a id be detached f		9 ☐ Unknown  Part II. Other significant con-			a in the u	Inderhina c	ause and	n in Part	1	23e Did	tobacco u	se contribute to	the cause of de	ath?
ds,	signe d be d	d by	DIABE	TES ME	=LLI	+ 1	JS	2030 9140	orrain care			Yes 2[		. /	
COL	w requir been si should	iete									24a. Was	s an	24h Were au	tonsy findings as	vailable
Re	The far te has age 2	Completed									auto perf		death?	topsy findings as completion of cau	use of
Vital Records,	ding Physician: The taw h. After this certificate has t funeral director, page 2 s	BeC	25. Was case referred to med examiner?	tical					26. Place	e of Death	1 ☐ Yes (Check only		1 105	2LJ N0	
)f \	hysic his ce	ို	1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpa				_	41900	_			5 ☐Other (Spec	cify)	
Division of	ling P	lon:	27. Manner of Death  1 Chatural 5 Per		ojury 28t Day Year)	D. Time o Injury		Bc. Injury Work	:?		28d. Describe	how injur	y occurred		
isio	i or Attendi after death. Diractor: A I in by the fu	licat	3 ☐ Suicide 6 ☐ Co	estigation uld not be 28e Place of I	Injury - At home,	farm st	M reet factory		/es 2□		28f. Location	(Street and	d Number or Ru	ral Route Numbe	IA.
Ď	ai or A s after i Dirac	Certification:	4  Homicide det	building,	etc. (Specify)	, iaiii, su	reet, lactory	, onice			City or To	wn, State	)	rai riodio raino	07,
	To the Hospital or Attending Physician: within 24 hours after death.  To tha Funeral Diractor: After this certifical completely filled in by the funeral director.	Medicai (	29a. Certifier 1 Certi (Check only 2 Medi	ifying Physician: To the bes cal Examiner: On the basis and manner	of examination	dge, deat and/or in	h occurred a	at the tim in my op	e, date ar pinion, dea	nd place, a ath occurre	and due to the	cause(s) , date and	and manner as place, and due	stated. to the cause(s)	
	To the within To the comp	M	29b. Signatura an Cittle of cer	trier	RN	1-1	29c	License	number	60		29d. Dat	e signed (Monti	2.00°	5
	Λ		3d Nama and address + per	sonwho poppieted called of	death (Item 23)	a) (Not	9rh10 -	AK	217	CHI	E H	(G)+	WAY	,	
			31. Date filed (Month, Day, Yo	ear) 32 Pagi	strar's Signature	BÃ	1711	106	Z.E.	M	ARY	LAN	VD-	2/22	5
	Sta Registr	-		8 2005	M. Signature	1	make 1				,				
DH	IMH 17 Rev 1/20	001	ALIN &	, o coos   Do	W 10.	1	77								

		1	For Amend Item 6 p	State of Marylar er fh G842 4	id / Depa -29-05 <i>Cel</i>	artment of H	ealth and Death	Mental Hyg	jiene eg. No.?	05	113446
	Physicia		1. Decedent's Name (First, Middle, Last)  Cynthia Lynn Tuck					2. Date of Dea Month April	th Day	Year 005	3. Time of Death 1:39A M
	/Medic Examin		4a. Fecility Name (If not institution, give str 123 Glendale Ave.			4b. City, Town, or				ty of Death	_
	Funeral Director	,	5 Social Security Number 6, Sex	7. Age (in yrs.		If Under 1 Year Months Days	If Under 24 Hrs Hours Min		1961		place (State or Foreign ntry) 1 and
	ט		Usual Residence of Decedent  10a. State 10b. County  MD Anne Aruno		ty, Town or Lo						10d. Inside City Limits 1 ☐ Yes 🏋 No
	with the h	Direct	10e. Street and Number 123 Glendale Ave			10f. Zip Code 2106	1		10g. Citizen o	f What Cou	
36	permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health end Mantel Hygiene. Department of Health end Mantel Hygiene important: if item 27 is marked other than "naturel; or items 23e or 28e-f show important: if item 27 is marked other than "naturel; or items 23e or 28e-f show all high or any injury or other treumatic event, the Medical Evant and must be notified at once.	by Funeral Director		2. Was Decedent Ever in U Armed Forces? 1 _ Yes _ 2 \overline{N} No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba  1 Yes 2 No	ispanic Origin? (: in, Mexican, Pue Specify:	Specify Yes or No- to Rican, etc.)	В	ace - Ameri lack, White, city: Whit	, etc.
	within 72 hour ene. than "naturel	Completed	15. Decedent's Educa (Specify only highest grade Elementary/Secondary (0-12)	ation	(Give life.	dent's Usual Occup kind of work done DO NOT use retired	during most of wo		16b. Kind of		·
	ld be filed within entel Hygiene. Ked other than '	To Be Cor	12 17. Father's Name (First, Middle, Last) Charles Fowler		F:	inance Re	18. Mother's Na	.st .me (First, Middle, .a Hofman	Maiden Sum		L
Maryland	nd 2 shou lith end M 27 is mar r treumat		19a. Informant's Name/Relationship (Type Robert O. Tucker	e, Print)	72555	ng Address (Street					
Baltimore,	Peges 1 ar	,	20a. Method of Disposition  1 Burial 2 Coremation 3 Re 4 Donation 5 Other (Specify)	State	Place of Disponentery, cre	osition (Name of matory or other place w Cremato	ce)	Date 25/2005	20c. Locatio	n-City or T imore	own, State, MD.
Balti	permit. Departn importe any inju	(	21. Signature of Funeral Section 10 on the	MUNIC	A		neral Ho			Sulph	ur Spring Rd
	Physician /Medical Examiner	ner	23a. Part 1. Enter the disease, or complice shock, or heart failure. List only one immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury)	Due to (or se a conse	equence of):	rlanoma	, 300, 25 oct o				Interval Between Onset and Death
8760,	ate be executed hysicien and the burial-transit	Ical Examiner	Cause (Disease or injury that initiated events c. resulting in death) Last	Due to (or as a conse	equence of):						
O. Box 6	ath certific thending p	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ₩ No 9 □ Unknown	Bc. If yes, outcome of preg 1 Live birth 2 Fe 4 Pregnant at time of 9 Unknown	tal death 3	□Ectopic pregnanc □ Other (specify) _	у		23d.	Date of deli Month	very Day Year
Δ.	juires that the de signed by the a lid be detached i	þ	Part II. Other significant conditions con	tributing to death but not re	esulting in the	underlying cause gi	ven in Part I.	23e. Did t			the cause of death?
I Records,		Completed						24a. Was auto perfo 1  Yes		prior to death?	topsy findings available completion of cause of 2 No
Vital	Phyeician: The this certificete har all director, page	o Be	25. Was case referred to medical examiner?  1  Yes	ospital: 1 ☐ Inpatient 2	☐ ER/Outpatio	ent 3 DOA Ot	26. Place of D	eath (Check only of Home 5 Nesi	dence 6 🗆	Other (Spec	cify)
ion of	ding Ph I. After th funeral	atlon: T	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time Injury	of 28c. Inju		28d. Describe			
Division	o the	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At building, etc. (Spe	home, farm, s	street, factory, office		28f. Location ( City or To	Street and N wn, State)	umber or Ru	iral Route Number,
	Hospitei	edical	29a. Certifier 1 Certifying Physical Check only one)	sician: To the best of my k ner: On the basis of exami and manner stated.	nowledge, de: ination and/or	ath occurred at the t investigation, in my	ime, date and pla opinion, death or	ce, and due to the curred at the time,	date and pla	d manner as ce, and due	stated. to the cause(s)
	To the	M	29b. Signature and title of certifier				38409		29d. Date si	gned (Monti	h, Day, Year)
-	8		30. Name and address of person who co	[mail 1975]	Fally	Rel # 717	r, L-Me	ulle, he	( 210	93	
	S Regis	ate	31. Date filed (Month, Day, Year) APR 2 8 200	3. Registrar's Sig	gnature	od.					

		•	1 - For State Registrar	State of	of Mary	land / Dep <i>Ce</i>	artmer <i>rtifica</i> i			and M	-	jiene leg. No.	05	14447
			1. Decedent's Name (First, Middle,	Last)							2. Date of Dea Month		Year	3. Time of Death
	Physicia /Medic		Edythe	G.	V	assar					April	25,	2005	7:05 a <sup>M</sup>
	Examin		4a. Facility Name (If not institution,	give street and nu	mber)		4b. City		Location of	of Death		4c. Cou	nty of Death	
			EDENWALD  5. Social Security Number	6. Sex	7 Age //	yrs. last birthday)	If Unde	Tow:	SON If Under:	24 Hrs.	8 Date of Birth		Baltim	ace (State or Foreign
	Funeral Director		275-10-1883	1 □ M 2 0 F	91	Yrs.	Months		Hours	Min.	8. Date of Birth (Month, Day June 10	Year) 913	3 0hi	try)
	p		Usual Residence of Decedent			0: T								
	shov	'n	10a. State 10b. County MD Baltin	20.00		c. City, Town or Lo	ocation						10	0d. Inside City Limits 1 ☐ Yes 2 ☑ No
	28a-f	rect	MD Baltin  10e. Street and Number	iore		owson	10f. Zip	Code				Ioa. Citizen	of What Coun	
	3e or	Funeral Director	800 Southerly Ro	ad			212					ISA		,.
	death	ner	11. Marital Status	12. Was Dec	edent Eve	r in U.S. 13.	Was Dece	dent of H	ispanic Original	gin? (Spe	ecify Yes or No- Rican, etc.)	14. F	Race - America	
36	or its		1 Never Married 2 Marrie	d 1 Tes	2 ⊡ <b>*</b> No ve		1 ☐ Yes		Specify:	, , , ,	1 110411, 010.7	Spe	, h	
ë	hours tural	ed b	3 ☐ Widowed 4 ☐ Divorced	Year or E	ates:	16a Dece	dent's Usu	al Occup	ation				Business/Ind	ueto
215	within 72 hours after death with the Maryland ene. than "natural", or items 23e or 28e-f show he Madical Examinational Le notified at	Completed by	(Specify only highest	grade completed) College (	1-40r 5+)	(Give	kind of wo	rk done o	during most	t of worki	ng	100. 14.10 01	200110331110	a stry
21	filed with Hygiene. other than	Com	Elementary/Secondary (0-12)	College	1.401.54)	Class	ified	Acc	ounts	Rep	).	Balti	imore S	Sunpaper
nd	be file	Be	17. Father's Name (First, Middle, L								(First, Middle,	Maiden Sum	ame)	
Maryland 21215-0036	should be ind Mental s marked o umatic eve	ဥ	David Henry Br 19a. Informant's Name/Relationsh	OWN		10h Maili	na Address		Emma		lahon Il Route Numbe	r City or Tou	m State Zin	Cadal
	42 A A A A A A A A A A A A A A A A A A A		Dean L. Vassar	/ son							in, MD		vii, Diaio, Zip	0000)
Je,	ss 1 ar		20a. Method of Disposition			20b. Place of Disponentery, cre	osition (Na.	me of	- 1		Date		n - City or To	wn, State
Ē	Page ment o		1 X Burial 2 ☐ Cremation 1 4 ☐ Donation 5 ☐ Other (Sp	ecify)	State	.akeviéw				4/2	28/05	Sykesv	/ille,	MD
Baltimore,	permit. Pages 1 and Department of Healinportent: If item 2 any injury or other 2000.		21. Signature of Fune al/Survice L	Gensee					s of Facility n Fun		Home		York	Road 21204
Ī			23a. Part1. Enter the disease, or o shock, or heart failure. List of	complications that	caused the	death. Do not en	ter the mod	de of dyin	g, such as	cardiac o	or respiratory arr	est,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)	_ a	(8)	rowar	1//	ant	en	de	seme			Onset and Death
	/Medical Examiner		rooding in doubly	Due to	(or as a co	onsequence of):	,	•	٠,	CU20-	1			///
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to	(or as a co	onsequence of):	- 1	an	- )	مرار ع	grome			190
	cate be executed bhysicien and the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c		After	26	len	lu_	d	serve			(Oyrs
8760,	be exi	ai Ey	residing in death) East	Due to	(or as a co	ons quente of):								
687		edicai		đ.										
Box	death certific e attending p id for use as i	M/W	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, ou			⊐⊏atasia s					23d. I	Date of delive	y
	0 00	by Physician/Me	in the past 12 months?		nant at tim		□Ectopic p □ Other (s <sub>i</sub>						Month	Day Year
P.0	that the de ed by the a detached t	Phy	9 Unknown > Part II. Other significant condition			ot regulting in the u	indochina (	nauco aine	on in Port I		23e Did to	hacco use co	ontribute to th	e cause of death?
ds,	se us	d by	ratti. Ottor significant condition	is continuating to c	oatii butii	or resulting in the t	indenying (	ause give	on ar carri.		1 □ Y	./	3 Proba	
Records,	w requir been si should	Completed									24a. Was a	n 241	b. Were autop	sy findings available
	The lav	omp									autops perfor	SV	prior to con death?	ipletion of cause of
Vital		BeC	25. Was case referred to medical examiner?						26. Place	of Death	(Check only or	7		
of V	Physic this ce	၉	1 ☐ Yes 2 ☐ No		Inpatient	2 ER/Outpatie		-	Nu	-	me 5 Resid			)
OU C	ding F h. After funera	tion:	27. Manner of Down  1 Defaural 5 Pending 2 Accident investiga		of Injury oth, Day Ye	28b. Time of Injury	M .	28c. Injun Work	rat <br Yes 2 ∐ i		28d. Describe h	ow injury occ	urred	
Division	Attending Physicien: r death, ector: After this certific by the funeral director.	fica	3 ☐ Suicide 6 ☐ Could n	ot be 28e. Plac	of Injury	- At home, farm, st			.03 20.		28f. Location (S	treet and Nu	mber or Rural	Route Number,
ā	s after s after bl Dire	Certification;	4 Homicide	build	ing, etc. (	Specify)					City or Tow	n, State)		
	To the Hospitel or Attending within 24 hours after death.  To the Funerel Director: After completely filled in by the funer	Medical	29a. Certifier 1 Certifying (Check only one)	xaminer: On the t	best of m asis of ex aner stated	ny knowledge, deat amination and/or in	h occurred vestigation	at the tim	ne, date and pinion, deat	d place, a	and due to the c ed at the time, d	ause(s) and late and plac	manner as sta e, and due to	ated. the cause(s)
	To the within 2 To the complet	Σ	29b. Signature and title of certifier	4		. /	29	c. License	number	<u></u>	2	9d. Date sign	ned (Month, L	Day, Year)
	10	-		/1/	-/	rysar	4	)	4	16	,4	71	08	05
(	0 1		30. Name and address of person v	no completed cau	se of deati	1 (Item/23a) (Type,	Print)	16	N	Rol	liz k	1 13	Balto	hy
	Sta Registr		31. Date filed (Month, Day, Year)  APR 2 8	2005	negistrar's	Signature A	ents!				0	1	- , ,	

			1 - For State Registrar	State	of Marylan		artment rtificate			nd Me			000			
			Negistrar     Nededent's Name (First, Middle, I	_ast)			incare	- 01 L	- Call	1:	2. Date of De	Reg. No.	005	3 Time of Death		
	Physici /Medic		Frances	M. We	athers	tein				1	April	25 <sup>Day</sup> 2	2005 Year	2:45p <sup>M</sup>		
	Examin		4a. Facility Name (If not institution, g	nive street and n	umber)		4b. City, T	Town, or	Location of	f Death			ounty of Death	2.450		
		٠.	Riverview Nu	rsing	Center		Ess	sex				Ba.	ltimor	e		
	Funeral Director		5. Social Security Number 6 215-22-1030	Sex 1 M 2 Tr	7. Age (In yrs. 76		If Under 1 Months	Days	If Under 2 Hours	Min.	8. Date of Bird (Month, Da Dec . 2	y, Year)	Сои	place (State or Foreign ntry) Land		
	PG &		Usual Residence of Decedent  10a. State 10b. County		10c Cit	ty, Town or Lo	cation							10d Inside City Useria		
	sho	5		imore	100. 01	•	sex							10d. Inside City Limits 1 ☐ Yes 2 🛣 No		
	28a-1	Director	10e. Street and Number				10f. Zip (	Code				10a Citiza	en of What Cou			
	Sa or		922 Garden D	rive			TOI. Zip		1221			USA		inity:		
	ms 2	Funerai	11. Marital Status	12. Was De	cedent Ever in U	.S. 13. 1	Was Decede	ent of His	panic Orig	in? (Spec	ify Yes or No	- 14	. Race - Ameri			
20	thin 72 hours after death with the Maryland e. an "natural", or items 23e or 28e-f show Medical Evaninar must be notified at	by Fur	1 ☐ Never Married 2 🙀 Married 3 ☐ Widowed 4 ☐ Divorced	Armed F 1 ☐ Yes If Yes, G Year or	2√∑ No Sive		fYes, speci 1 ☐ Yes 2		Specify:	, Puerto R	lican, etc.)	s	Black, White, Specify:Whi			
Z 13-0030	2 hou		15. Decedent's	Education		16a. Deced	dent's Usual	l Occupa	tion		-		d of Business/in			
2	within 72 ene, than "nat	Completed	(Specify only highest Elementary/Secondary (0-12)		(1-4or 5+)		kind of work DO NOT use		uring most	of working	g			•		
V	e filed within Hygiene. other than vent, the M	Con	8th			Home	maker	<u> </u>				own	home			
yland	~ @ <del>**</del> *	Be	17. Father's Name (First, Middle, La	st)							(First, Middle,					
2	es 1 and 2 should be 1 of Health and Mental I fitem 27 Is marked o r other traumatic eve	ပ္	Frank Hess								t Mul					
Mar	12 sh h and 7 Is m traum		19a. Informant's Name/Relationship		/		-						Town, State, Zij e MD 2			
D)	1 and Health em 27 ther tr		Edward Weathe	erstein		A STATE OF THE PARTY OF THE PAR					Dalt.		ation - City or To			
altimore,	Pages nent of int: If it		Marial 2 ☐ Cremation 3  4 ☐ Donation 5 ☐ Other (Spe		n State Sa	Place of Dispo cemetery, crer credHe	natory or oth eartc	her place of Je	ຶ່ :su\$4				ltimor			
Dail	permit. Pages Department of I Important: If ite any injury or of		21. Signature of Funeral Service Lic		10	22	2. Name and	d Addres	s of Facility	'Coni	nelly	une	ralHom	eofEssex		
	40240		220 Part Sator the disease or o	To In	nell	4					Balt:		e MD 2	1221 Approximate		
			23a. Part1. Enter the disease, or o shock, or heart failure. List or	y one cause on	e do line.	U U a	er the mode	, ,	-			rrest,		Interval Between Onset and Death		
	Physician /Medical		disease or condition resulting in death)													
	Examiner		Due to (or as a consequence of):													
		ē	Sequentially list conditions, if any, leading to immediate	b. — Due to	o (or as a conseq	quence of):										
1	outed id ansit	Examin	Cause (Disease or injury that initiated events													
, ,	an ar	Ĕ	resulting in death) Last	Due to	o (or as a conseq	quence of):										
8/60,	cate be executed physician and the burial-transit	dicai		d												
Ó			IF FEMALE:									1				
X Q	death certifi e attending p od for use as	Physician/M	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live	utcome of pregna birth 2 Feta	al death 3	Ectopic pre					23	ld. Date of delive Month	ery Day Year		
		ysic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4∐Prej 9□Unk	gnant at time of o known	death 5L	Other (spe	ecify)								
J.	w requires that the de been signed by the s should be detached	h h	Part II. Other significant condition	s contributing to	death but not res	sulting in the u	nderlying ca	use give	n in Part I.		23e. Did t	obacco us	a contribute to t	he cause of death?		
ds	uires sign Id be	d by	DM, +	HTN		Lahon		1		onh	10	Yes 2□	No 3∏Prol	pably 4 Denknown		
S	w req	iete			,						24a. Was	an	24b. Were auto	opsy findings available		
Ř	he la e has age 2	Completed									auto	osy ermed?_	prior to co death?	impletion of cause of		
<u>e</u>	an: T	Be Co	25. Was case referred to medical		-				26 Place	of Death	1 Yes		1 🗆 Yes	2 D No		
5	ysici is cer direct	0	examiner? 1 ☐ Yes 2 ☑ No	Hospital:	Inpatient 2	ER/Outpatier	nt 3 🗆 DO/	A Othe	_				□Other (Speci	(v)		
0	g Ph ter th	T :u	27. Manner of Death	28a. Dat	e of Injury onth, Day Year)	28b. Time o	f 28	3c. Injury Work			8d. Describe			,,		
<u> </u>	auth. oath. or: Af	atic	1 Natural 5 Pending 2 Accident investiga	tion	,,	,,	М		es 2□N	No						
DIVISION OF VITAL RECORDS,	after de Directo	Certification;	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	ad 280. Pla	ce of Injury - At h Iding, etc. (Special	ome, farm, str fy)	reet, factory,	, office		28	8f. Location ( City or To	Street and wn, State)	Number or Run	al Route Number,		
	To the Hospital or Attending Physician: The law requires that the within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached.	Medical C	Check only 2   Medical Ex	caminer: On the	he best of my kno basis of examina	owledge, deat ation and/or in	h occurred a	at the tim in my op	e, date and inion, deat	d place, ar	nd due to the d at the time,	cause(s) a date and p	nd manner as solace, and due to	stated. to the cause(s)		
	the the mple	Med	one)  29b. Signature and title of certifier	and ma	inner stated.			. License					signed (Month,			
	E 2 E 8		Marc M	D.						54		04-	26-	2005		
	4		30. Name and address of person w			m 23a) (Type,	Print)	- P2 D	nl	RI	ND	M	-0 - 2	2005		
	-1		31. Date filed (Month, Day Year)	SEBM.			1731	ER	74	10	· ·			, – ,		
	Sta Regist	ate rar	31. Date filed (Month, Day, Year) APR 2 8	2005	Registrar's Signa	H for	Bull.									

		For State Registrar  Decedent's Name (First, Middle, La.	State of Ma	aryland		ificate of		2. Date of Deat	g. No.	2005	3. Time of Death	
Physician /Medical Examiner		Dwight T. Wil a Facility Name (If not institution, give 108 Lincoln Ave			G	len Burn			Ann	2005 unity of Death e Aruno		
Funeral Director	2	Social Security Number 15-03-4339 6. Signal Residence of Decedent	ex 7. Ag X□M 2□F	e (In yrs. las 87	Yrs.	If Under 1 Year Months Days	If Under 24 Hr. Hours Min		) 1 7	9. Birthp Cour	place (State or Fore htry) MD	
death with the maryland ms 23a or 28a-f show finding by notified at		Oa. State 10b. County MD Anne Art	undel	10c. City, 1	Fown or Loc G1e	n Burnie	2				0d. Inside City Lim 1 ☐ Yes 2 📉	
rifer death with the marking terms 23s or 28s-1's report to the providing terms of the contract of the contrac		0e. Street and Number 108 Lincoln Ave	•			10f. Zip Code 21061				of What Cour	itry ?	
al, or ite	5	Marital Status     Never Married	12. Was Decedent Armed Forces? 1 ☐ Yes 2 💆! If Yes, Give Year or Dates:			as Decedent of H Yes, specify Cub ☐ Yes 2X No		Specify Yes or No- rto Rican, etc.)		Race - Americ Black, White, pecify: Whi	etc.	
within 72 has ene. then "netu then "netu		15. Decedent's E. (Specify only highest grade) Elementary/Secondary (0-12)	ducation ade completed) College (1-4or 5	5+)	16a. Decede (Give k life. De Posta		pation during most of wo d) Ler	orking .		of Business/Inv		
marked other Imatic event, I		7. Father's Name (First, Middle, Last) Franklin Wilson	n				Mary I	me (First, Middle, M Dagenhart				
trail	1	9a. Informant's Name/Relationship (  Jean Wilson / w			108 L	incoln A	venue, (	iural Route Number Glen Burn:	-			
. Pages 1 an Iment of Heel tant: If Item 2 Jury or other	2	0a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐  4 ☐ Donation 5 ☐ Other (Specif		20b. Place com Meac	dowrid	_	ial 4/29	9/05	Elkri	ion-City or To	)	
permit. Pag Department Important: If any Injury o once.	2	21. Signature one a Service Licer	1598	40141	/ 1	Name and Addre	ss of Facility S ve SW G1	Singleton en Burnie	Fune MD :	ral Hom 21061	ne P.A.	
Chysician /Medical Examiner	1 0 0	23a. Part 1. Enter the disease, or com shock, or heart failure. List only mmediate Cause (Final disease or condition esulting in death)  Sequentially list conditions, any, leading to immediate ause. Enter Underlying cause (Disease or injury nat initiated events estimated to the conditions of the con	a. Due to (or as b. Due to (of as c. HP	AUSC a consequer 3 E T 25 a consequer	nce of 1/2 nce of):	TIC (O	PONAM S AND	y Horas	er O	Jeorgs E	Approximate Interval Between Onset and Death D	
ysicie ne bur		Due to (or as a consequence of):  d. DYS LOPIO ENTIA									YEARS	
d by the attending phy lielached for use as the Physician/Medic	11 2	F FEMALE:  3b. Was decedent pregnant in the past 12 months?  1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal de	eath 3 E	ctopic pregnanc Other (specify)	/	23d. Date of d Month			ery Day Year	
as been signed by the 2 should be detached	P	art II Other significant conditions of	contributing to death b	ut not resultin	ng in the und	lerlying cause giv	ren in Part I.	23e. Did tob	_		ne cause of death? ably 4 Unkno	
ate h page	_	CHrange (	REAME	FA	TZI	nE.		24a. Was al autops perform 1 □ Yes 2	red?	4b. Were auto prior to co death? 1 \( \sum \text{Yes}	psy findings availal npletion of cause of	
this certificate	1	5. Was case referred to medical examiner?	Hospital:	nt 2 TER	R/Outnation!	3C DOA 0#	Or.	eath (Check only on Home 5 Reside		Other (Secsif	d	
Affication: To	inpatient 2 EH/Outpatient 3 DOA 4 Nurs							28d. Describe ho			,	
S e e		3 Suicide 6 Could not be determined	building, et	c. (Specify)				28f. Location (St. City or Town	, State)			
within 24 hours a vithin 24 hours a completely filled		Pa. Certifier 1 Certifying Ph (Check only 2 Medical Examinal)  9b. Signature and title of certifier	ysician: To the best niner: On the basis of and manner sta	f examination	edge, death n and/or inve	estigation, in my of	pinion, death occ	eurred at the time, da	ite and pla	d manner as si ace, and due to igned (Mopth,	the cause(s)	
- 3 - 8			2 ,	4.0.		DI		CAR GU		• ' /	* * * * * * * * * * * * * * * * * * * *	
	3	O. Name and ad ss of person who	completed cause of d	leath (Item 2	3a) (Type, P	rint		Y = "		\	1.210	

## Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

				State of N	naryland / De	Certificate o			leg. No.		
	Physic /Medi		1. Decedent's Name (First, Midd Woodrow V					2. Date of Dea		Year	3. Time of Death 1:40 p.m.
1	Exami		4a. Facility Name (If not institution Long Viev	on, give street and number V Nursing Ho			4b. City, Town, or Manches	Locetion of Death	4c. County		
	Funeral Director		5. Social Security Number	6. Sex 1]□ M 2□ F	oge (In yrs. last birtho	Months Day			Year) 917	9. Birthpla Counti Kentu	ace (State or Foreign ry) 1Cky
	eryland show del	_	Usual Residence of Decedent  10a. State  10b. County	,	10c. City, Town o	or Location					d. Inside City Limits
	he M	ecto	MD Carr  10e. Street and Number	·oll	Manc	hester					1 ☐ Yes 2 ☐ No
	with with	늅	4441 Millers	Ctation Da		10f. Zip Code		1	0g. Citizen of V		у?
	death	Funeral Director	11. Marital Status	12. Was Deceden	t Ever in U,S.	13. Was Decedent of If Yes, specify Cu	Hispanic Origin? (S	pecify Yes or No-		e - America	
020	filed within 72 hours after death with the Meryland Hygiene. ther than "natural", or items 23a or 28a-f show ont, the Medical Examiner must be notified at	ğ	1 Never Married 2 Mar 3 Widowed 4 Divorced	If Yes Give	Mo	If Yes, specify Cu		to Rican, etc.)	Specify	k, White, el Whit	
5-0	72 ho	ted	15. Deceder	nt's Education est grade completed)	16a. D	ecedent's Usual Occ	upation	rkina	16b. Kind of Bu		
21215-0020	within ane.	Completed	Elementan Secondary (0-12)	College (1-4or	5+)	live kind of work don fe. DO NOT use retii	e during most or wo	iking		200	
d 2	Hygie Hygie ther t	ပိ	17. Father's Name (First, Middle,	Last)	Coa	al Miner	18 Mother's Na	me (First, Middle, I		Mines	i
lan	ild be lental ked o ic eve	To Be	Harrison Wi	•			Rosa	no (i not, imadic, i	naiden damam	9)	
Maryland	nd 2 shou Ith end M 27 is mar treumat	<b>F</b>	19a. Informant's Name/Relations Eschol Amelia S	ship (Type, Print) , studnitz/Dau	19b. M ghter 444	lailing Address (Stree	et and Number or Ri Station	ural Route Number	city or Town,	State, Zip C	20de)
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Merylan Depertment of Health end Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other treumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition  X☐ Burial 2 ☐ Cremation	3 ☐Removal from State	20b. Place of D cemetery,	isposition (Name of crematory or other p	ace)	Date 20	20c Location -	City or Tow	m, State
ij	nit. P entme ortani injury		4 ☐ Donation 5 ☐ Other (S 21. Signature of Funeral-Service	•	campue.	Ll Mem. Ga 22. Name and Add		11 . 27,	Campbel	I Co.	Tennesse
ä	Dependent in the second in the		1415	Plant		Eckhardt	Fringral	Chapel,	P.A.		
	Physician /Medical Examiner	Immediate Cause (Final disease or condition resulting in death)  Immediate Cause (Final disease or condition resulting in death)  Due to (or as e consequence of):								Approximate Interval Between Onset and Death	
	end end I-transit	xamine	Sequentially list conditions, if any, leading to immediate	<b>f</b> b	Due to (or as a cor	isequence of).					
68760,	rificete be executed og physician end es the burlel-transit	Physician/Medicai Examiner	Sequeritially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	C	Due to (or as a con	sequence of):					
. Box	death cer s ettendin d for use	ician/	Part II Other significant condition	d.	but not requiting in th		iron in Don't	OOD Did to			
, P.O	es thet the de igned by the e be detached i		Part II. Other significant condition	Ars commoding to death i	but not resulting in th	e underlying cause g	wen in Part I.	236. Did to			he cause of death? bly 4  Unknown
of Vital Records,	aw requir is been s 2 should	Completed by						24a. Was en	n autopsy ned?	aveila	e autopsy findings able prior to pletion of cause ath?
<u>~</u>	The la	ខ្ល						1□ Ye	s 2 1 No	101	Yes 2 No
Z Z	ysician: The Is certificate director, pag	Be	25. Was case referred to medica examiner?	Hospital:				ith (Check only on	э)		
ō	Phys raldi	2	1 ☐ Yes 2 ☐ No  27. Manner of Death	1 LI Inpati	,	MIGHT 3LI DOA		ome 5 Reside			
0	Attending Physician: r death. ector: After this certific. by the funeral director,	tion	1 Matural 5 ☐ Pendir 2 ☐ Accident investi		ay Year) Inju	ry Wo	ork? ]Yes 2∐No	26d. Describe no	w injury occurre	,u	
in the	p # ¥ = =	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	nined 28e. Place of in	jury - At home, farm, tc. (Specify)	street, factory, office		28f. Location (Sti City or Town	reet and Numbe , State)	or Or Rural F	Poute Number,
	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	edical C	29a. Certifier (Check only one)	ng Physician: To the best Examiner: On the basis of and manner st	of examination and/or	eath occurred at the trinvestigation, in my	ime, date end place opinion, death occu	, and due to the ca rred at the time, da	use(s) and mar ite and place, a	nner es stet nd due to th	ed. ne cause(s)
	To the within 2 To the complex	Me	29b. Signature end title of certifie		1	29c. Licen	se number	29	d. Date signed	(Month, Da	ıy, Year)
			1 July	V- Molk	leton in	1 7	25442		4/18	2005	
	3		30. Name and address of person	who completed cause of	4 4 4	pe, Print)	25443 Doad, V		/ -		
			31. Date filed (Month, Day, Year)	idale for		Poole 1	and, V	Vistmins	ter, Y	hD!	21157
П	Sta Registr		APR 2 8 20	105 Registi	rar's Signature				,		,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 10 PM WILLIAMS **Physician** GLORIA APRIL 26 2005 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** BALTIMORE JOHNS HOPKINS BAYVIEW MEDICAL CENTER BALTIMORE If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. (ast birthday) 8. Date of Birth Birthplace (State or Foreign
 Country) 5. Social Security Number Year) 94 **Funeral** Days Hours 1 □ M 2 🗷 F Virginia Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 28a-f show other traumatic event, the Medical Examiner must be notified at Baltimore Catonsville 1 Yes 2 No Funeral Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ö 21228 309 or Items 23a 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 1□Yes 2☑No Specify: Black Specify: þ 3 Widowed 4 Divorced and Mental Hygiene. Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Manufacturer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) rmit. Pages 1 and 2 should be file partment of Health and Mental Hy portant: If item 27 is marked oth y injury or other traumatic event Baker Baker Watkin 19b. Mailing Address (Street and Number of Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Catonsville, mo Saunders 21228 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or othe Burial 3,□Cremation 3 □Removal from State andalistown, mo Department of Important: If any injury or once. King Memonal 4 Donation 5 Other (Specify) 21. Signature Funeral Service Linesee 22 Name and Address of Facility JORY P. MARCH FIH 870 FREDHILTON PASS BALTOMO 21225 Effer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, for heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) ASPIRATION PNEUMONIA DAYS Priysician /Medical Due to (or as a consequence of) Examiner 6 MONTHS ISCHEMIC CARDIOMYOPATHY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner The law requires that the death certificate be executed 10 YEARS KIDNEY DISEASE CHRONIC Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Division of Vital Records, 2 No 3 Probably 4 Unknown 1 ☐ Yes Be Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death? 2 🗆 No 1 Yes 1 Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 \( \text{Nursing Home} \) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 ☐ Residence 6 ☐ Other (Specify) P 1 ☐ Yes 2 No 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 1 Natural 5 Pending investigation 1 □ Yes 2 □ No 2 Accident Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Funeral Dir.
To the Funeral Dir. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Comparison of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and trill of certifier 29c. License number RES 000 APRIL 26, 2005 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

3

State

Registrar

DAVID COSGROVE 31. Date filed (Month, Day, Year)

APR 2 8 2005

Baltimore, Maryland 21215-0036

P.0.

ORIGINAL

32. Remistrar's Signature

GOO NORTH WOLFE STREET, NELSON 106, BALTIMORE, MARYLAND, 21287

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** JAN 11 2005 12:59 A VICTOR TADJOSSI-ANANI /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MONTGOMERY BETHESDA NATIONAL NAVAL MEDICAL CENTER If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) JAN 11 2005 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Min. Months 1 □ XM 2 □ F MARYLAND Director N/AUsual Residence of Decedent the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-1 show traumatic evant, the Madical Examiner must be notified at 1 ☐Yes 2 ☐ No DISTRICT OF COLUMBIA Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with ment of Health and Mental Hygiene.
ant: If item 27 is marked other then "natural", or Items 23s or ury or other than "natural", and it is unather uny or other traumatic event, Ite Mandical Examiliat count be a UNITED STATES 20010 1498 SPRING PLACE Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 X Never Married 2 Married 1 ☐ Yes 2 📉 No Baltimore, Maryland 21215-0036 Specify: BIJACK If Yes, Give Year or Dates: 1 ☐ Yes 2 X No Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 0 N/A17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be FAWIYE TADJOSSI ABALO ANANI ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1498 SPRING PLACE WASHINGTON DC 20010 FAWIYE TADJOSSI/MOTHER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If any injury or ones. \* 4 ☑Donation 5 ☐ Other (Specify) - Bethesda 3 Bethesda 21. Signature of Funeral Service Consee 22. Name and Address of Facility arma Bethesda 8901 Wistonsin Joney 23a. Rart1. Enter the disease, or completations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final EXTREME PREMATURITY Pnysician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Unseaso or irriury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner Hospital or Attanding Physician: The law requires that the death certificate be executed the burial-transit Due to (or as a consequence of). Box 68760, physician IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, pe 2 No 1 Yes 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 rmed? 2 🔀 No certificate 1 Yes director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ **X**o 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Injury 1 🗆 🔀 tural 5 Pending 1 ☐ Yes 2 ☐ No death. 2 Accident investigation after death Diractor: 3 Suicide 6 Could not be determined Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2

To tha complet 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year) RES-000 30. Name and ad ress of person who completed cause of death (Item 23a) (Type, Print) NATIONAL NAVAL MEDICAL CENTER BETHESDA MD 20889-5600 KAIVON ARFAA LT MC Rº2 8 2005 32. 2 State Registrar

·			1- FoAmend Item #26 State RegistrarWCHD/SH 4/19  1. Decedent's Name (First, Middle, Last)	State of /05 per	Marylan r Dr.		artmen tificate			and M		Reg. No.	2000	3. Time of Death
	Physici /Media Examir	cal	James Alvin Bower  4a. Facility Name (If not institution, give s		iber)		4b. City,	Town, or	Location	of Death	Month April	Day 16,	Year 2005 County of Dea	11:00 P <sup>M</sup>
	Funeral	ier	9204 Jordan Road  5. Social Security Number 6. Sex		7. Age (In yrs.	last birthday)		rpla 1 Year			8. Date of Bir (Month, Da		Washing	
	Director			M 2□F	74	Yrs.	Months	Days	Hours		(Month, Da June 3(			ryland
	n 72 hours after death with the Maryland "neturel", or Items 23e or 28a-1 show salical Examiner must be notified at	Director	10a. State 10b. County  Maryland Washingt	on		y, Town or Lo	ort							10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	with the or 2		10e. Street and Number 8819 Downsville Pi	ماد			10f. Zip	Code 21795					izen of What Co	ountry?
	death ms 23	Funeral		2. Was Dece	dent Ever in U	.S. 13. )				gin? (Spe	cify Yes or No		14. Race - Am	
900	ours after reil, or ite	þ	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed For 1 Tes If Yes, Give Year or Da	<sup>2</sup> ₹No		fYes,spec	_	n, Mexican	n, Puerto f	Rican, etc.)		Specify: Wh	
Maryland 21215-0036	I within 72 ho iene. r than "netur the Medical	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)		4or 5+)	life. I	kind of wor DO NOT us	rk done d se retired	<i>turina</i> mosi	t of workir	ig		ind of Business	
d 21	t Syg		12 17. Father's Name (First, Middle, Last)			Cabin	et Ma	ker	18. Mothe	er's Name	(First, Middle			Manuf.
'lan	Mental Parked of	To Be	Lloyd Edward Bower	s					Anna	Rebe	ecca Ba	ker		
lary	d 2 should th and Men 7 Is marke traumatic		19a. Informant's Name/Relationship (Ty)										r Town, State,	Zip Code)
	s 1 and f Health item 27 other tr		Belinda E. Rupp -	daughte		9204 Place of Dispo			i. Fa		ay,MD		3 ocation - City or	Town State
nor	m O		1 ☑ Bunal 2 ☐ Cremation 3 ☐ R  '4 ☐ Donation _ 5 ☐ Other (Specify)	emoval from S	state	emetery, crem en lawn	natory or or	ther plac		-20-				rt,Maryland
Baltimore,	permit. Page Department Important: If any injury or once.		21. Signature of Fyneral Service License			22	. Name an	d Addres	s of Facilit	y0sbc	rne Fu	nera	I Home,	
	Physician /Medical Examiner price and price pric	Examiner	23a. Part1. Enter the glsease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (d	or as a consequence as a consequence	juence of):	ly	mp	h a	0		1		Approximate Interval Between Onset and Death
.O. Box 68760,	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	Physician/Medical E	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	3c. If yes, outd	come of pregnant 2 Feta	ancy	Ectopic pro						23d. Date of de Month	livery Day Year
<u>α</u>	puires that the signed by all be detact	Ď	Part II. Other significant conditions con	tributing to de	ath but not res	ulting in the u	nderlying ca	ause give	en in Part I.		23e. Did t			o the cause of death?
Vital Records,	The ate h page	Completed									24a. Was autop perfo 1 \( \text{Yes} \)			utopsy findings available completion of cause of
Vita	Physicien: r this certific ral director,	Be	25. Was case referred to medical examiner?	ospital:		22.00		Othe	ar		(Check only o	ne)	1	Daughter's
ō		tlon; To	1 Yes 2 No  27 Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date o	patient 2 f Injury n, Day Year)	28b. Time of Injury		8c. Injury Work	4 U Nu		e <b>E</b> 8d. Describe	how injur		ecify) nome
Division	ial or Attending s after death. el Director: After ed in by the fune	Certification;	3 Suicide 6 Could not be determined	28e. Place buildin	of Injury - At hog, etc. (Specif	ome, farm, str (y)	eet, factory	, office		2	8f. Location ( City or To			ural Route Number,
	To the Hospital or Atte within 24 hours after de To the Funerel Directo completely filled in by tt	edical	29a. Certifier (Check only one) Certifying Phys	ician: To the er: On the ba and mann	sis of examina	owledge, death tion and/or in	occurred avestigation,	at the tim	e, date and pinion, deat	d place, a th occurre	nd due to the d at the time,	cause(s) date and	and manner as I place, and due	s stated. e to the cause(s)
	To the within 2.	Σ	29b. Signature and title of certifier			1 M	) 29c	. License	number	, H		29d. Dat	te signed (Mont	th, Day, Year)
,			30. Name and address of person who co	m leted cauce	of death (lto-	DOLL n 23a) /Tune	Print)	1-	146	41	5	A	phi	18,2005
3	H-0		Hind Hom	day	) _M	0 1	30		OPI	AL	CT	1.1	Joden	town, m/
	Sta Regist		31. Date filed (Month, Day, Year) APR 19 20	)5 32.	egistrar's Signa	ature)	معظمه			1				7 110

			1 - For State Registrar		Maryland / De		ent of H		and M		iene ()	05	1445	es. Aug
	Physici	an	Decedent's Name (First, Middle, Last							2. Date of Dea Month	Day	Year	3. Time of Dea	
	/Media	cal	EVELYN WILSON B			41- 6	No. Town	• AU	(0	APRIL	7	2005	1325	М
	Examir	ier	HEARTFIELDS	Sireet and numbe	")	40. 0	City, Town, or EAS		or Death			nty of Death		
	Funeral		5. Social Security Number 6. Se		Age (In yrs. last birtho		nder 1 Year	If Under		8. Date of Birth			place (State or Fo	eign
	Director		430-28-8577 Usual Residence of Decedent	□M 2\\ F	82 Yrs	Mon	ths Days	Hours	Min.	JAN 16	1923	TEX	(AS	
	hours after death with the Maryland turel', or Items 23a or 28a-f show at Examinet must be notified at	<u>_</u>	10a. State 10b. County	200	10c. City, Town o								10d. Inside City Li	
	within 72 hours after death with the Marylan piene. r then "neturel", or Items 23a or 28a-1 show The Madical Examinet must be notified at	Funeral Director	MD TALI	301	EA	STON	. Zip Code				On Citizen	of What Care	Yes 2	140
	Sa or	Dir	700 PORT ST.			101	216	0.1			lug. Citizen	of What Cou	-	
	death ms 2:	nera	11. Marital Status	12. Was Deceder		13. Was D	ecedent of Hi	spanic Ori	gin? (Sp	ecify Yes or No-		USA Race - Ameri	can Indian,	
٥	after or Ite	Fu	1 Never Married 2 Married	Armed Force: 1 ☐ Yes 2 1 If Yes, Give			specify Cuba es 212 No	n, Mexicar Specify:		Rican, etc.)		Black, White,		
2	hours urel',	d by	3 Widowed 4 Divorced	Year or Dates									HITE	
ဂ်	n 72 "net	Completed	15. Decedent's Edi (Specify only highest grad	de completed)	(C	ive kind o	Usual Occupa f work done o OT use retired	during mos	t of work	ing	16b. Kind o	f Business/In	ndustry	
7 7	within giene. r then	mo	Elementary/Secondary (0-12)	College (1-4o 4	r 5+)		E PERS		L		TRAVE	L AGEN	ICY	
פט	ent,	BeC	17. Father's Name (First, Middle, Last)	············				18. Mothe	er's Name	e (First, Middle,	Maiden Surr	name)		
<u>Z</u>	should be ind Mental marked c	70	JAMES M. WILSON					LOI	LA M	. JETTON	I			
Maryland	s 1 and 2 should f Health and Mer item 27 le marke other traumatic		19a. Informant's Name/Relationship (7)			ailing Add	ress (Street a			al Route Number			o Code)	
	ts 1 and of Healt item 2 other		CLAUDE F. BRICE,  20a. Method of Disposition	JR./HUSE	20b. Place of D	sposition	X 538 (Name of			MARYLAN Date		54 on - City or To	own. State	
Baltimore,			X☐ Burial 2 ☐ Cremation 3 ☐  '4 ☐ Donation 5 ☐ Other (Specify		oxford		or other plac TERY		4-9-2				RYLAND	
	교 된 본 경 .		21. Signature of Funeral Service Licens		1			1		1				
ń	Depa Impo any ii		Joseph m. D.	sfronk.	CF.SP	FELLO 200 S	WS, HE	LFENI	BEIN ST 1	& NEWNA	M FUN	ERAL H 601	IOME PA	
	Physician /Medical Examiner up particular up provided in the prize	I Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. ————————————————————————————————————	The imenas a consequence of)		Disin	126			55 7 70		Onset and Deat	-
P.O. Box 6	The law requires that the death certificate ite has been signed by the attending physionage 2 should be detached for use as the	ed by Physiclan/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown  Part II. Other significant conditions co	4☐ Pregnant 9☐ Unknown	2 Fetal death at time of death	5 Othe	oic pregnancy r (specify) ing cause give	an in Part I.		23e. Did to	bacco use c		ery Day Year he cause of death	
Vital Records,		Completed								24a. Was a autops perform	sy	b. Were auto prior to co death? 1  Yes	opsy findings avail impletion of cause 2 No	able of
VII:	Physiclen: this certific ral director,	Be	25. Was case referred to medical examiner?	Hospital:			Othe	ar:		h (Check only or			ASSIST	ID.
ō	ling Phy I. After this uneral d	tlon: To	1 ☐ Yes 2 ☑ No  27. Manner → Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	1 ☐ Inpa 28a. Date of Ir (Month, I		e of	28c. Injury Work	4 LI NU		me 5 Reside 28d. Describe he		Other (Specificurred	LIVING	
Division	el or Attending s after death. Il Director: After ed in by the fune	Certification:	3 Suicide 6 Could not be determined	28e. Place of	Injury - At home, farm etc. (Specify)	, street, fa	ctory, office			28f. Location (Si City or Town		mber or Rura	al Route Number,	
	To the Hospitel or within 24 hours after To the Funerel Dire completely filled in b	edical C	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	ysician: To the be iner: On the basis and manner	st of my knowledge, of examination and/ostated.	leath occu or investiga	rred at the timation, in my op	ne, date an pinion, dea	id place, ith occurr	and due to the cred at the time, d	ause(s) and ate and plac	manner as s	stated. o the cause(s)	
	To the within To the comp	Me	29b. Signature and title of certifier	15/	////		29c. License	number	, ,	2	9d. Date sig	ned (Month,	Day, Year)	
			Loulling !	166	also,	m	P	5146	6		4/8	105	-	
			30. Name and address of person which				/ <b>/ / / / / / / / / / / / / / / / / / </b>	A CITICAL		01601	1			
	CA	ato.	LUDWIG J. EGLSE	/	503 IDLEV	ATPD	VE. E	ASTON	, MD	21601				
	Sta Regist		APR 1	Kana	And Shirt Shirt	5-4	A STATE OF THE PARTY.							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registral Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Apr 22, 2005 **Physician** 14:31 Wesley Bartlett Bovd /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 220 E. Mary Street Cumberland Allegany If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. Mar 26, Mar 26, 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral X**□ M 2□ F 215-26-9945 Yrs Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits Show Pages 1 and 2 should be filed within 72 hours after death with the Maryla nent of Health and Mental Hyglene.
snit if item 27 Is marked other then "neturet", or Items 23e or 28e-1 show and it of the reumatic event, if a Medical Examination must be notified at MD Allegany Cumberland Y□Yes 2□No Completed by Funeral Director 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 220 E. Mary Street 21502 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerlo Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married Ž Married 1 Yes 2 No If Yes, Give Year or Dates: 1 Yes 2 No Baltimore, Maryland 21215-0036 Specify: Specify: white 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) .aborer Tire Co. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Rosco L. Bartlett Lucille Boyd Bartlett 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
220 E. Mary Street Cumberland MD 21502 Anna Bartlett wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State permit. Page Department of Importent: If any injury or once. Scarpelli Funeral Home, PA 4/23/2005 MD Cresaptown 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens 22. Name and Address of Facility
Scarpelli Funeral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 Approximate
Interval Between
Onset and Death
ZOOR YNJ 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Immediate Cause (Final MUTASTATIC CANCER OF WNGS **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year ŏ in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐ Pregnant at time of death 5 Other (specify) P.0. the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Be Completed by PROS MITE CANCER 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 No fo the Hospitel or Attending Physiclen: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 esidence 6 Other (Specify) P 1 Yes 2 2 N 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? Certification: 28d. Describe how injury occurred Natural 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation after death Director: 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funerel E 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of PITYSICIAN 30. Name and address of completed cause of death (Item 23a) (Type, Print) MD. GN SETON PRIVE CUMBORUMD MAD would as e 31. Date filed (Month Day

DHMH 17 Rev 1/2001

State

Registrar

ORIGINAL

32 Registrar's Signature

2005

			For State Registrar	State of Mar	-	artment of I tificate of		ind Menta	l Hygier	0000	11.1.50			
I	Physici	an	Decedent's Name (First, Middle, Last)  Decedent's Name (First, Middle, Last)  The state of the state of	1		· · · · · · · · · · · · · · · · · · ·		Mon	of Death	2005 Year	3. Time of Detath			
	/Medic		Dorothy Thelma B  4a. Facility Name (If not institution, give s	ond treet and number)		4b. City, Town,	or Location o	Apr:		lc. County of Deatl	1:29 P M			
	LXamiii	CI	Shady Grove Advent		tal	Gaither			1	Montgomer	ry			
	Funeral Director		032-12-7420	7. Age (	(In yrs. last birthday) 81 Yrs.	If Under 1 Year Months Days		Min. 8. Date (Mor	of Birth oth, Day, Yea	9. Birth 1923 New	nplace (State or Foreign untry) York			
	show	or	Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or Lo						10d. Inside City Limits			
	28a-f	rect	Maryland Montgomer  10e. Street and Number	У	Silver Spi	10f. Zip Code			100.0	Citizen of What Co				
	3a or	Ö	14506 MacBeth Driv	re		20906			US		,			
36	be filed within 72 hours after death with the Maryland ttal Hygiene. do other then "naturel", or items 23s or 28s-f show event, the Medical Examination routile.	by Funeral Directo	11. Marital Status  1 Never Married 2 Married 3 XWidowed 4 Divorced	2. Was Decedent Ev Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	- 1	Was Decedent of f Yes, specify Cult		gin? (Specify Yes , Puerto Rican, e	s or No- stc.)	14. Race - Amer Black, White				
1215-0036	c * @	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0·12)	ation	)	dent's Usual Occu kind of work done DO NOT use retire	ipation during most ed)	of working		Kind of Business/I	Industry			
2	filed within Hygiene. other then "	Co	17. Father's Name (First, Middle, Last)	2	Socia	l Worker	10 Matha	da Nama /First		mily Serv	rices			
ylanc	should be filed within and Mental Hygiene. marked other then matic event, the Mental County the Mental	To Be	Henry Pierce	1-1-1-1			Berth	r's Name (First, a a Lawson	n					
<u>a</u>	d 2 sh th and th su treum	1	19a. Informant's Name/Relationship (Typ		1					or Town, State, Z				
Baltimore, Maryland 21	Pages 1 an nent of Heal int: if item 2 iry or other		Arlene B. Bond/daughter  14506 MacBeth Drive Silver Spring, MD 20906  20a. Method of Disposition  1 Burial 2 **Cremation 3 Removal from State*  1 Bond/daughter  14506 MacBeth Drive Silver Spring, MD 20906  20b. Place of Disposition (Name of cemetery, crematory or other place)  W. Arundel Crematory  20c. Location - City or Town, State  20c. Location - City or Town, State  20c. Location - City or Town, State  20c. Marval and											
Baltii	perriit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 is marked any njury or other treumatic evonce.		21. Signature of Funeral Service License		GG MO1251 Be	Name and Addr Ding HOM Everly L	ess of Facility e Crem • Heck	2005 ation Se rotte, I	ervice	enton, Ma P.O. Bo larksvill				
Í	Physician /Medical		23a. Part1. Enter the disease, or complice shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	cations that caused the cause on each line		ing, such as	cardiac or respira	atory arrest,		Approximate Interval Between Onset and Death IMP NUTES				
8760,	eate be executed hysician and the burial-transit	dical Examiner		YARS										
O. Box 6	death certif e attending d for use a	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at tii 9 ☐ Unknown	Fetal death 3	Ectopic pregnand	су			23d. Date of deli Month	very Day Year			
ds, P.	uires that i signed by Id be deta		Part II. Dther significant conditions con	tributing to death but	not resulting in the u	nderlying cause g	iven in Part I.	236	e. Did tobacc	o use contribute to	the cause of death?			
Record	The law requires that the ate has been signed by the page 2 should be detache	Completed by	MORBID OBE	siry	/			-	a. Was an autopsy performed Yes 2X1	prior to death?	topsy findings available completion of cause of			
Vita	icien: sertific actor,	Be (	25. Was case referred to medical examiner?	la a sitali				of Death (Check	k only one)					
Division of	To the Hospitel or Attending Physicien: The I within 24 hours after death.  To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	tlon: To	1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	ospital: 1  Inpatient 28a. Date of Injury (Month, Day)		f 28c. Inju		28d. De		6 ☐ Other (Speci jury occurred	cify)			
Divis	tel or Attendi s after death. al Director: A ed in by the fu	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injur- building, etc.	y - At home, farm, str (Specify)	eet, factory, office	9	28f. Loc City	ation (Street or Town, Sta	and Number or Ru ate)	ral Route Number,			
	To the Hospitel or At within 24 hours after d To the Funeral Direct completely filled in by	dical	(Check only 2 Medical Examin	sician: To the best of ner: On the basis of e and manner state	examination and/or in ed.	vestigation, in my	opinion, deal	th occurred at the	e time, date a	ind place, and due	to the cause(s)			
	To t To t	Ž	29b. Signature and title of certifier			29c. Licer	nse number	2./	29d. [	Date signed (Month	n, Day, Year)			
	10	0	30. Name and address of person who compared to the filed (Month, Day, Year)  APR 1 3 200	mpleted cause of dea	ath (Item 23a) (Type,	Print)	5-	4	MA	KIL Y	2005			
	Sta	to	JAVID SROUR A 31. Date filed (Month, Day, Year)	1.D. 990 3 Registrar	/ Medica	al CFK	PRIVE	e Koch	tu///e	17d 2	0850.			
	Regist	ar	APR 13 200	5 Herry	J. Apr	Me								

			For State Registrar	State of Maryland		artment of Heal		ntal Hygie	211115	14457
	Physici /Medic		1. Decedent's Name (First, Middle, Last)  John		B	itting	A		Day Year	3. Time of Death 5 11. 45A M
	Examir Funeral		4a. Facility Name (If not institution, give s  Renaissance Garden  5. Social Security Number 6. Sex	7. Age (In yrs. la	st birthday)		ring	Date of Birth (Month, Day, Ye	4c. County of Dea	
	Director		207-10-1866  Usual Residence of Decedent  10a. State 10b. County		Nown or Lo			ct.15,1		nsylvania
	72 hours after death with the Maryland "natural", or items 23a or 28e-1 show salsal Exur: it at mark be rediffed at	Funeral Director	Maryland Montgomer 10e. Street and Number 3118 Gracefield Roa	ad CC219 2. Was Decedent Ever in U.S	lver	Spring 10f. Zip Code 20904 Was Decedent of Hispanif Yes, specify Cuban, Me	nic Origin? (Specif		Citizen of What C	
5-0036	hours after of turel', or item at Exurciner	by	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces?  1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: WW I	I	1⊡Yes 2⊠No <i>Sp</i>	exican, Puerto Rid			hite
2121		Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	ation completed)  College (1-4or 5+) 5+	(Give	dent's Usual Occupation kind of work done during DO NOT use retired)	g most of working		o. Kind of Business ederal Ti Commiss	ade
Maryland	2 should be filed and Mental Hygic Is marked other eumetic event, II	To Be (	17. Father's Name (First, Middle, Last)  Miles Thomas Bitt:  19a. Informant's Name/Relationship (Type)		19b. Mailir	18. Manage Address (Street and N		ora Boye	den Sumame)	
Baltimore, Ma	permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygiene, importent: If Item 27 Is marked other than any lailury or other treumetic event, ITEM ODGS.	and the second s	Dorothy M. Bitting 20a. Method of Disposition 1	Wife    20b. Pla   20b. Pla   cer   Gate	3118 ace of Disponentery, cree of H C	Gracefield sition (Name of natory or other place) eaven emetery 2. Name and Address of F 0 University	Apr. 15 Facility Fran v Blvd	219 Sil 200 ,2005Sil cis J. (	lver Spri Location - City of Lver Spri Collins I	ing, MD 20904 r Town, State
	Pnysician /Medical		23a. Pant1. Enter the disease, or complic shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	cations the caused the death. e cause in each line.  Due to (or as a conseque	Prev	1ver Spring or the mode of dying, such	, Mary Lan ch as cardiac or re	d, 2090.		Approximate Interval Between Onset and Death 2 WILKS
8760,	ate be executed hysicien and he burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseque	Parka ence alla	enson's d	hsease			
P.O. Box 6	death certifii s attending p d for use as	Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	ic. If yes, outcome of pregnand 1 ☐ Live birth 2 ☐ Fetal of 4 ☐ Pregnant at time of dea	death 3	Ectopic pregnancy Other (specify)			23d. Date of de Month	blivery Day Year
	sigr sigr	by	Part II. Other significant conditions con	tributing to death but not result	ting in the u	nderlying cause given in F	Part I.		_	o the cause of death?
Vital Records,	The law aste has by page 2 sh	Completed						24a. Was an autopsy performed	prior to death?	utopsy findings available completion of cause of
n of	Attending Physicien: Th r death. sctor: After this certificete by the funeral director, pag	ation; To Be	25. Was case referred to medical examiner?  1  Yes 2  Ho  27. Manner of Death 1 Natural 5  Pending investigation		R/Outpatier 28b. Time of Injury	t 3 DOA Other:	28d		e 6 □Other (Spe	ocify)
Division	To the Hospitel or Attendir within 24 hours after death. To the Funerel Director: Al Completely filled in by the fu	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hom building, etc. (Specify)	ne, farm, str	eet, factory, office	28f.	Location (Street City or Town, St	t and Number or R tate)	ural Route Number,
	the Hospi in 24 hou the Funer	edicai	(Check only 2 Medical Examin	ician: To the best of my knowler: On the basis of examination and manner stated.	ledge, death on and/or in	vestigation, in my opinion	n, death occurred a	at the time, date	and place, and du	e to the cause(s)
)	P P P	Σ.	29b. Signature and title of certifier Part	//	4D	D S9 S		_	Date signed (Mon.	th, Day, Year)
6	***   +		30. Name and address of person who con LOVEEM J. PUTH C	MANA, 3110	GRA	CEFIELD R	LOAD S	ILVER S	PRING,	MD 20904
	Sta Registr		31. Date filed (Month, Day, Year)  APR 1 4 201	32 legistrar's Signatu	re do	ali				

			Please	State of M				f Health and	•	•	
			For State	State of W	iarytari			of Death		/ 11115	14450
			Registrar  1. Decedent's Name (First, Middle, La	ast)			incate	or Beaut	2. Date of Death	g. No.	3. Time of Death
Phys			Robert H. Beal	L					April 1	1, 2005 Year	8:20 p M
/Me Exan		-	4a. Facility Name (If not institution, given		)		4b. City, Tov	n, or Location of Dea		4c. County of Oeath	-1
		B	6102 Twin Point	Cove Road				Cambridge		Dorches	
Funera			,	Sex 7. A		ast birthday) Yrs.	If Under 1 Y Months D	ear If Under 24 Hrs ays Hours Min	8. Date of Birth (Month, Day	Year) 9. Birth	ington D.C.
Directo	or	-	217-36-9282 Usual Residence of Decedent		67	115.			Nov. 15	, 193/ <u>Wash</u>	ington D.C.
yland			10a. State 10b. County		10c. City	, Town or Lo	cation				10d. Inside City Limits
9 Mar		cto	Maryland Dorches	ster			Cambr	idge			1 ☐ Yes 2 ☐ No
िक् हो । (से 28 (से 28		Olre	10e. Street and Number	0 01			10f. Zip Co		10	g. Citizen of What Co	
s 23a		Funeral Director	6102 Twin Point					21613			SA
ter de	١,	Ë	11. Marital Status  1 □ Never Married 2 ☑ Married	12. Was Decedent Armed Forces 1 1 es 2	?	5. 13.1	If Yes, specify	of Hispanic Origin? ( Cuban, Mexican, Pue	to Rican, etc.)	14. Race - Amei Black, White	
hours af	١.	2	3 Widowed 4 Divorced	If Yes, Give Year or Dates:			1 ☐ Yes 2 ☐	No Specify:		Specify: Wh	ite
INCLESSES OF SECUCION OF SECUC		Completed	15. Decedent's E (Specify only highest gi	ducation		16a. Deced	dent's Usual O	ccupation	orkina 1	6b. Kind of Business/I	ndustry
Mithin Ne.		ğ.	Elementary/Secondary (0-12)	College (1-4or	5+)			one during most of wo attred)			
Hygie ther ther ther			17. Father's Name (First, Middle, Las	<i>t</i> )		Line	Engin		me (First, Middle, M	Teleph	one
d be file bental Hy ked oth c event	1	o Be	Robert Clemen						DeNeane	alderi Gamanie)	
A B T Y B T T T T T T T T T T T T T T T T		င္	19a. Informant's Name/Relationship			19b. Mailir	ng Address (St			City or Town, State, Z	ip Code)
ING 2 alth a alth a 27 is			Marie A. Beall/S	Spouse		12307	7 Thomps	son Rd., B	owie, MD 2	20720	
of He rothe			20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 [	□ Bomouni from State		lace of Dispo	sition (Name o	place)	Date 2	0c. Location - City or	own, State
Pages ment of ent: If it			* 4 □Donation 5 □ Other (Special	ify)	Mid					Cambridge,	Maryland
Baltimore, IMaryliar permit. Pages 1 and 2 should be Department of Health and Menta Importent: If item 27 is marked eny injury or other traumatic e	once.		21. Signature of Funeral Service Lice	insee	, , , , , , , , , , , , , , , , , , , ,	10/0	Name and A	ddress of Facility Fromwell F n St., Cam	uneral Hor	ne. P.A.	
	a		agenton	ILE DE	1MC	vect3	308 Hig	n St., Cam	bridge, M	21613	Approximato
Tev V			23a. Enter the dise se, or or shock, or heart failur Lin only Immediate Cause (Final	one cause on each	line.	1. Do not sint				50,	Approximate Interval Between Onset and Death
Physicia /Medic			disease or condition resulting in death)	a. Due to (or a	mal	1 ee	u u	ng Car	an		Imonth
Examine	er			Due to (or a	s a consequ	161106 01).		1			
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or a	s a consequ	uence of):					
acuted and transi		Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c							
/ 6U, e be executed /sician and e burial-transit	!		resulting in death) Last	Due to (or a	s a consequ	ience of):					
ys to		dicai		d							
Goath certifica e attending ph	1	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom			_			23d. Date of deli	verv
Geath death e atte		iciai	in the past 12 months?	1☐Live birth 4☐Pregnant a			∃Ectopic pregn ∃ Other <i>(specil</i>			Month	Day Year
by the tache		hys	9 🗆 Unknown	9□ Unknown							
COTGS, P.O. w requires that the de been signed by the should be detached		by	Part II. Other significant conditions	contributing to death	but not resu	ulting in the u	nderlying caus	e given in Part I.	/	acco use contribute to	
w require been si should I		ompleted							1 Yes	S 2∐No 3∏Pro	obably 4 Unknown
fec e taw has b e 2 st	-	nple							24a. Was an autopsy perform	prior to c	topsy findings available ompletion of cause of
VITAL MEC sicien: The taw certificate has b		O							1 Yes 2	IPNo 1 ☐ Yes	2 🗆 No
	- 1	o Be	25. Was case referred to medical examiner?  1 Yes 2 No	Hospital:	tiont 2	ER/Outpatier	2 DOA	Othor	eath (Check only one	) nce 6 Other (Spec	
	- 1	-	27. Manner of Death	28a. Date of Inj (Month, D	jury	28b. Time of		Injury at	28d. Describe hov		19)
Attending Pr r death. ector: After thi		atio	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigate	on	ay (ear)	Injury	М	Work? 1 ☐ Yes 2 ☐ No			
		Certification:	3 Suicide 6 Could not determined	d 28e. Place of II	njury - At ho etc. (Specify	me, farm, str	reet, factory, of	fice	28f. Location (Stre City or Town,	eet and Number or Ru. State)	ral Route Number,
Ditel of urs af pref D											
DIVISION  To the Hospitel or Attendin within 24 hours after death. To the Funerel Director: Aft completely filled in by the fur		edicai	29a. Certifier 1 Certifying P (Check only one) 2 Medical Exa	nysician: To the bes aminer: On the basis and manners	of examinal	wledge, deatl tion and/or in	h occurred at ti vestigation, in	ne time, date and place my opinion, death occ	e, and due to the cau surred at the time, dat	use(s) and manner as te and place, and due	stated. to the cause(s)
To the within 2 To the comple		Me	29b. Signature and title of certifier		1		29c Li	cense number	29	d. Date signed (Month	. Day, Year)
O			> Klude	MM				139887		4/13/01	7
			30. Name and address of person who	completed cause of	death (Item	23а) (Туре,	Print)			1	
			David H. Smith,	M.D., 29	466 Pr	nteil	Drive,	Easton, 1	D 21601		
Regi	Stat		31. Date filed (Month, Day, Year)	1 4 2005 Regis	trans Signa	ture	Rome	R.A			
neg	ioti c			-	THE PARTY OF	AND SECOND	A STATE OF THE PARTY OF THE PAR				

			1 - For State Registrar	State of Marylar		artment of rtificate of			Reg. No.	005	14459
	Physici /Medio Examin	al	1. Decedent's Name (First, Middle, Last  AGNES Ann  4a. Facility Name (If not institution, give	Bigelser	1	4b. City, Town,	or Location of De	2. Date of De Month	1 13	Year 05 hty of Death	3. Time of Death
	Funeral Director		Union Hospital of 5. Social Security Number 077 10 0383		Ven	Elkton If Under 1 Year Months Days			ay, Year)		olace (State or Foreign try) York
Maryland 21215-0036	filed within 72 hours after death with the Maryland Hygiene. other than "natural", or itams 23a or 28a-f show ent, I'le Madical Examiner must be notified at	Be Completed by Funeral Director	Usual Residence of Decedent  10a. State  10b. County  Maryland Cecil  10e. Street and Number  100 Laurel Drive  11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  15. Decedent's Edit (Specify only highest grade)  Elementary/Secondary (0-12)  9  17. Father's Name (First, Middle, Last)	12. Was Decedent Ever in L Armed Forces? 1  Yes, Give Year or Dates:	ity, Town or Location  J.S. 13.  16a. Decer Give life.	10f. Zip Code 21921	pation of wind and with a during most of wind and and a second and a s	(Specify Yes or Narto Rican, etc.)  Forking  ame (First, Middle	10g. Citizen o  United  14. R. Bl  Special  16b. Kind of	State ace - Americ ack, White, ify: whi	0d. Inside City Limits  Variable Yes 2 □ No  ntry?  S  an Indian, etc.
Baltimore, Maryla	permit. Pages 1 and 2 should be Department of Health and Mental Important: if item 27 is marked or any njury or other traumatic events.	To	Gottleib Reinhard  19a. Informant's Name/Relationship (7.  Agnes Albright/Dau  20a. Method of Disposition  1	nghter  20b. Removal from State	80 Fi Place of Dispo commetery, creat rerdale	neburg R esition (Name of matory or other pla Cremato 2. Name and Addr	Road Nort	Rural Route Numb The East M Date 11 17, 2005 Crouch Fu	laryland 20c. Location Newark Ineral H	1 2190 n - City or To L Dela Home	1 own, State
8760,	Physician and /Medical Examiner the prival-transit	dical Examiner	23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consect.  Due to (or as a consect.  Due to (or as a consect.  Due to (or as a consect.)  Due to (or as a consect.)	quence of):		•		irrest,		Approximate Interval Between Onset and Death  Conferment  Conferme
.O. Box 6	death certifi e ettending ed for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 menths? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome of pregn 1 □ Live birth 2 □ Fet 4 □ Pregnant at time of 9 □ Unknown	al death 3[	Ectopic pregnand Other (specify)	су			Date of delive Month	ery Day Year
s, P	requires been sign should be	by	Part II. Other significant conditions on	ontributing to death but not re	sulting in the u	nderlying cause g	iven in Part I.	1 🗆	Yes 2□No	3 Prob	
Vital Record	The fa ate has page 2	Be Completed	25. Was case referred to medical examiner?				26. Place of D	24a. Was auto perf 1 \sum Yes	prsy ormed? 2 No	prior to cor death?	psy findings available mpletion of cause of
Division of V	Phys rthis ral dii	Certification: To	27. Manner of Death  1 Natural 5 Pending investigation  2 Accident Suicide 6 Could not be	28a. Date of Injury (Month, Day Year)	ER/Outpatier 28b. Time o Injury	f 28c. Inju	ury at ork? ] Yes 2 □ No		how injury occi	urred	
Divi	e Hospital or Attending 24 hours after death. e Funeral Diractor: After letely filled in by the fune		4 Homicide determined  29a. Certifier 1 Certifying Phy	building, etc. (Spec.	owledge, deat	h occurred at the	time, date and pla	City or To	wn, State)	manner as st	I Route Number,
ì	To the He within 24 To the Fe completel	Medical	one	iner: On the basis of examin and manner stated.					29d. Date sign		Day, Year)
	12		30. Name and address of person who of Scholar (Month, Day, Year)  APR 1 5 200	ompleted cause of death (Ite	om 23a) (Type,	Print) Elk (	m MDZ	1921			
	Sta Regist	ar	APR 1 5 200	5 Klimer A	A South	when the					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** Louie Andrew Blake 2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** Union Hospital of Cecil County

Social Security Number 6. Sex 7. Age (In yrs. last birthday) Elkton. Ceci1 If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 1 → M 2 ☐ F 232 66 9944 62 June 18,1942 West Virginia Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County 1 X Yes 2 No Director Maryland Cecil **Elkton** 10f. Zip Code 10e Street and Number 10g. Citizen of What Country? 288 Hollingsworth Manor 21921 United States

14. Race - American Indian,
Black, White, etc. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 XYes 2 No 1962— If Yes, Give Year or Dates: 1965 1 Never Married 2 Married 1 ☐ Yes 2 🗓 No Specify: Specify: 2 3 XWidowed 4 ☐ Divorced white 1965 Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Truck Driver Trucking 18. Mother's Name (First, Middle, Maiden Sumame, 17. Father's Name (First, Middle, Last) Be Joseph H. Blake Lovey Fisher 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Guy Blake/Son 208 Rhudy Park, Elkton, Maryland 21921 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Mayerdale Crematory April 17, \*4 □Donation 5 □ Other (Specify) Newark, Delaware 21. Signature of Funeral Service License 22. Name and Address of Facility Crouch Funeral Home 127 South Main Street, North East, Maryland 21901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final cute disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 4 Pregnant at time of death 9 Unknown 5 Other (specify) Yes 2 No 9 Hunknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 3 Probably 4 Unknown 2 No 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 ☐ Yes 2 ☐ No 2 ner (Specify) 2 rred

The law requires that the death certificate be executed attending physicien and Division of Vital Records, P.O. Box 68760, the as õ signed by the a d be detached for should certificate or Attending Physician: funeral director this After nours after death.

nerel Director: Af within 24 hours a To the Funerel C

**Funeral** Director

worde |

permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: if item 27 is marked other than "naturel", or items 23s or 28e-f ehow any Injury or other traumatic event. The Wedigal Examiner must be notified at once.

**Physician** 

/Medical

**Examiner** 

Baltimore, Maryland 21215-0036

with the Maryland

1 2
-
1 70
1 4
- 4
90
1 22
15
1 2
1 =
1 0
1 4
_
- 64
1 9
1 3
1 5
1.5
10
-
1 3
1 2
1 5
1 6
- 9
1 20
- 9
- 1 ≥
1 4
1 4
. 4
1.00
- I 64
1 -
1 5
1100
15
1.

Medical Certification

				1 ☐ Yes 2 ☑ No				
5. Was case referred to medical	26. Place of Death (Check only one)							
examiner?	Hospital: 1 ☐ Inpatient 2 ☑ EF	R/Outpatient 3 DOA	Other: 4 Nursing Home	5 Residence 6 Ot				
7. Manner of Death 1 ☑ Natural 5 ☑ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of 28c. Injury	Injury al 28d. Work?	Describe how injury occur				

1 Yes 2 No investigation 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \( \text{Homicide} \)

(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s and manner stated.	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  (Check only 2) Madrical Experiment On the basic of experiments and/or investigation in my replicate, death occurred at the time, date have a latent and the cause of the ca
---	--

	one)	and manner stated.		
29b.	Signature and title of certifier		29c. License number	29d. Date signed (Month, Day, Year)
	1/1/1-2/1		5.53111	1001/11/

forms, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

10 n Luion 1- ay 31. Date filed (Month, Day, Year)

State Registrar

2005

			Flease	Type or Print				-	_	ne.
			For	State of Mary		epartment of H		fental Hyg	giene	05 11161
			1 - State Registrar			Certificate of	Death		Reg. No.	00 14401
	Dhysiai	200	Decedent's Name (First, Middle, Last	st)	-			2. Date of Dea Month		3. Time of Death
	Physici: /Medic		Wayne Herb	et Cur	mingh	a.m.		4	15 26	
	Examin		4a. Fecility Name (ff not institution, give	e street and number)	J	4b. City, Town, o	r Location of Death	,	4c. County o	f Deeth
			941 Kenwood	Drive		Hage . 5	itown		Wasi	hington
	Funeral		5. Social Security Number 6. S		n yrs. last birth	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth	h L Xearb	9. Birthplace (State or Foreign
	Director		210 31 2/10	<b>X</b> M 2□F	66 Yr	s.		MAYMong, Day	1930	MARYLAND
	D >		Usual Residence of Decedent  10a. State 10b. County	- 40	Oc. City, Town	as Location				10d. Inside City Limits
	aryla shor	7	N 1/4		oc. Oity, rowin		HAGERSTOWN	J		1 X Yes 2 No
	Se-f	octo		INGTON			TAGEKO TOM			
	or 2	Dire	10e. Street and Number 941 KENWOOD DRIVE			10f. Zip Code	21740		10g. Citizen of W	U.S.A.
	within 72 hours after death with the Maryland ene. Than "natural", or ltams 23a or 28e-f show the Medical Examina mula be notified at	by Funeral Director		1				" "		
	er de	une	11. Marital Status	12. Was Decedent Eve Armed Forces?	er in U.S.	<ol> <li>Was Decedent of H If Yes, specify Cubi</li> </ol>	hispanic Origin? (Sp an, Mexican, Puerto	Rican, etc.)	Black	- American Indian, , White, etc.
5	or or	γF	1 Never Married 2 Married 3 Widowed 4 Divorced	1 Yes 2 No If Yes, Give Year or Dates:		1 ☐ Yes 2 🌠 No	Specify:		Specify:	THITME
000	hour tural		15. Decedent's Ed		16a D	ecedent's Usual Occup	nation		16b. Kind of Bus	WHITE
<u>i</u>	n 72	let	(Specify only highest gra	ide completed)	102.0	Give kind of work done ife. DO NOT use retire	during most of work	ing	700. King of Das	in esserioustry
7	within lene. than	Completed	Elementary (Secondary (0-12)	College (1-4or 5+)			CENANCE		COUNTY I	BD. OF EDUCATION
0	al Hygie other		17. Father's Name (First, Middle, Last)	)			18. Mother's Nam	e (First, Middle,	Maiden Sumame	)
=	lid be Sental rked c	o Be	HERBERT CUNNINGHAI	М			MARY HI	ELEN UNK	NOWN	
<u> </u>	2 should be and Menta is marked sumatic ev	2	19a. Informant's Name/Relationship (		19b. N	Mailing Address (Street				State, Zip Code)
M	04 00 00 00		NANCY R. CUNNINGH	AM, SPOUSE	9.	41 KENWOOD	DRIVE, HA	AGERSTOW	N, MARYI	LAND 21740
ย์	s 1 and if Health Item 27 other tr		20a. Method of Disposition		20b. Place of D	Disposition (Name of crematory or other place		Date	20c. Location - C	City or Town, State
0	m O		1 Burial 2 Cremation 3 C 4 Donation, 5 Other Specif	THORITONAL HOLL STATE		BURG CREMAT		3/2005	SMITHSI	BURG, MARYLAND
Baitimor	artme ortan injur		1 ~/	27		22. Name and Addre				IONAL PIKE
n D	permit. Pages Department of Important: If I any injury or once.			erman	•		NERAL HOM		BORO, MA	
-	Ø 8		23a. Part1. Butar the disease, or comshock, or heart failure. List only		e death. Do no					Approximate
			shock, or heart failure. List only Immediate Cause (Final	one cause on each line.	1	•	3.			Interval Between Onset and Death
ŀ	hysician /Medical		disease or condition resulting in death)		ciatio	^				
	Examiner			Due to (or as a c	onsequence of	):				
		<u>-</u>	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a c	onsequence of	):				
	ted nsit	nin.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury							
_^	be executed ician and burial-transi	Examiner	that initiated events resulting in death) Last	C. Due to (or as a c	onsequence of	):				
9		al								
	w requires that the death certificate been signed by the attending phys should be detached for use as the	edic		, d						
×	certifical nding phy use as th	Ž	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of		_			23d. Date	of delivery
gox	death e atten ed for u	cla	in the past 12 months?	1 ☐ Live birth 2 [ 4 ☐ Pregnant at tim		3 ☐ Ectopic pregnancy 5 ☐ Other (specify) _	у		Mon	th Day Year
oj.	the cy the ichec	Physician/Medi	9 Unknown	9□ Unknown						
ο, J	requires that the een signed by th hould be detache	by Pl	Part II. Dther significant conditions of	contributing to death but r	not resulting in t	he underlying cause giv	ven in Part I.	23e. Did to	bacco use contri	bute to the cause of death?
S D	quires n sign							1 🗆 Y	es No	3 Probably 4 Unknown
Hecord	w rec	ompleted						24a. Was	an 24b. W	ere autopsy findings available
Ž Ž	The law cate has b page 2 si	E G						autop	rmed? de	for to completion of cause of eath?
_		CO	25. Was case referred to medical				00 81 (8)	1 ☐ Yes		Yes 2 No
		o B	examiner?	Hospital:	2 □ EB/Oute	patient 3 DOA Ott	26. Place of Deat		n <i>e)</i> lence 6 □Othe	· (C-aciba)
ō	Phys or this aral di	-	27. Manner of Death	28a. Date of Injury	28b. Tir				ow injury occurre	
0	ding F th. tuner	ţ.	1 Natural 5 Pending 2 Accident investigation	n (Month, Pay Y	rear) Inj		rk? ]Yes ZNo	Hone		
Division	al or Attendi after death. I Director: A d in by the fu	ertification:	Suicide 6 Could not b	1113/63		n, street, lactory, office		28f Location (S	Street and Numbe	r or Rural Route Number,
á	after Dire	erti	4 Homicide	Building, etc. (	_			City or I ou	n-Etate)	Della
	Hospital or Attending 14 hours after death. Funeral Director: After tely filled in by the fune	alC	29a. Certifier 1 ☐ Certifying Ph	nysician: To the best of r	ny knowledge,	death occurred at the til	me, date and place,	and due to the	cause(s) and man	iner as stated.
	e Hospital 24 hours a E Funeral I letely filled	edical	(Check only Medical Example)	miner: On the basis of ex and manner stated	camination and	or investigation, in my of	opinion, death occur	red at the time, o	date and place, a	nd due to the cause(s)
	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	Me	29b. Signature and title of certifier			29c. Licens	se number		29d. Date signed	(Month, Dey, Year)
•			Vorch	Denous La	Medel	Em. Do	056965		4/18/	65
			30. Name and address of person who	completed cause of deal	th (Item 23a) (T	7	100		- 1/3/	* *
5	1-7		251 E. Antie	tim St.	Hage	ostown	mo g	1740		
	Sta	ate	31. Date filed (Month Div. Yang 2	005 32 Registrar's	Signature	And.	*			
	Regist			A PERSON	fig.	STOCKEN .				

#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year Margaret Ellen Carnes 11, Apri1 2005 9:52 PM 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Mae's Country Home Jefferson Frederick If Under 24 Hrs. Hours Min. If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Months 1 ☐ M 2 🖸 F Yrs. 214-36-0042 08/19/1918 86 Virginia Usual Residence of Decedent 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 Ves 2 □ No Frederick Frederick 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 819 Geronimo Drive 21701 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2 → No If Yes, Give 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White 3 ₩ Widowed 4 □ Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Irvin Preston Athev Maude Leona Stocks 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Regina E. Stice 819 Geronimo Drive, Frederick, MD 21701 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Furnace Mountain Cem. 4/15/05 4 Donation 5 Other (Specify) Loudoun County, 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Colonial Funeral Home, 201 Edwards 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mole of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CONGESTIVE HEMPT MLUBE SEVEREL MOUTHS Due to (or as a consequence of) Due to (or as a consequence of): Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 2 No 1 Yes 3 Probably 4 Unknown INTESTINA JTRICTURE 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 26. Place of Death Check only one ASSISTED Other: 4 \sum Nursing Home

**Physician** /Medical Examiner

ed by the a

been signed by the should be detected

hes

certificete

this

To the Hospital or Attendir within 24 hours efter death.

To the Funerel Director: All completely filled in by the fu

or Attending Physicien: efter death.

certificate be executed attending physician end I for use as the buriel-transit

Division of Vital Records. P.O. Box 68760

Physician/Medical Examiner

þ

Completed

B

Certification: To

Medical

**Physician** 

Examiner

10a State

MD

Director

Funerai

ð

Completed

Be

Funeral

Director

show

r than "netural", or items 23s or 28s-f shorthe McCical Examiner must be notified at

permit. Pages 1 end 2 should be filed within 72 hours efter Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "netural", or ite any Injury or other traumatic event, the Medical Example

Saltimore, Maryland 21215-0020

death with the Meryland

/Medical

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

examiner?,	
examiner?	
27. Manner of Death	

5 Pending

30. Name and address of person who completed cause

KYNE

investigation 6 Could not be determined

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of

MUGANDA

28c. Injury at Work?

28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

29a. Certifier (Check only one)

Natural

2 Accident

3 Suicide

4 Homicide

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifie

D16675

19, 2005

State

31. Date filed (Month, Day, Year) APR 28 2005

BRUNSWICK Registrar's Signature

death (Item 23a) (Type, Print)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

DHMH 16 Rev 6/95

Registrar

28f. Location (Street and Number or Rural Route Number, City or Town, State)

5 ☐ Residence 6 X Other (Specify) LIVING

PACILITY

29d. Date signed (Month, Day, Year)

1. Decedent's Name (First, Middle, Last)  2. Date of Death Month Day Year  3. Time of Decedent's Name (First, Middle, Last)	1 - State Registrar			partment of <i>ertificate o</i>			.ornar i iy	Reg. N	00:	05	Senter the property of the pro	6
Edith M. Clough  40. Cloy Town or Loadin or Death  Cecil  Sour Severy Name (Fine crashinon, pow same and number)  94.2 Singer 1y Road  Committee of the committ	1. Decedent's Name (First, Middle, Last)	1						eath	300	Voor	3. Time of	Dea
9.42 Singerly Road  1. Our Size   Sur   Apr   7. Apr   6 yr   Lest birthout   Ver   Lest   Lest   Sur   Apr   6 yr   Lest birthout   Ver   Lest   Les	Ed:	ith M. Clo	ough								1607	]
\$ Social Security Number  224—223—223—22  Usus Resistance of Decedent  North East  100 City, Town or Localism  North East  100 City, Town or Localism  North East  100 City, Town or Localism  North East  100 City, Town or Localism  North East  100 City, Town or Localism  North East  100 City, Town or Localism  North East  100 City, Town or Localism  North East  100 City, Town or Localism  North East  100 City, Town or Localism  North East  100 City, Town or Localism  North East  100 City, Town or Localism  North East  110 West Passing City, Town or Localism  North East  110 West Passing City, Town or Localism  North East  110 West Deceded or Special Code  110 City as 20 No Special  110 West City, Town or Localism  111 Wast Deceded or Special City or Special Code  110 West City, Town or Localism  111 Wast Deceded or Special City or Special City or Special City or Special City or Special City or Special City or Special City or Special City or Special City or Special City or Special City or Special City or Special City or Special City or Special City or Special City or Special City or Town Special City or Tow						of Death		4			h	
224—22—3122 ITM 2 Ref 82 Vs. Months Days Hous Mr. McCort Day Yes Controlly Control Country  10c. Clty, Town or Location  North East  10c. Clty, Town or Location  North East  10c. Clty, Town or Location  North East  10c. Clty, Town or Location  North East  10c. Clty, Town or Location  North East  10c. Clty, Town or Location  North East  10c. Clty, Town or Location  North East  10c. Clty, Town or Location  North East  10c. Clty, Town or Location  North East  10c. Clty, Town or Location  North East  10c. Clty, Town or Location  North East  10c. Clty, Town or Location  North East  10c. Clty, Town or Location  North East  10c. Clty, Town or Location  North East  10c. Clty, Town or Location  North East  10c. Clty, Town or Location  North East  10c. Clty, Town or Location  10c. Clty, Town or Loc			Marine to Attabat			4 0 4 Usa	T					_
Total State and Number   Total Original Country   Total Original Coun	10	TH OME		Months Day			8. Date of Bi	rth ay, Year	7)	Col	untry)	Fo
Maryland Cecil North East 10%. Spread and Number 472 Bailiff Road 19.0. 2 Code 19.0		82					NOV 8	, 19	122	Vir	rginia	
Top. Streen and Number  472 Bailiff Road  10, 20, Code  21901  11 Was December of Historic Origin? (Spectry Vas or No- If Yas, spectry Coans, Manacan, Pueder Rican, etc.)  11 Page of Polymer of Poly	10a. State 10b. County		10c. City, Town or	Location							10d. Inside Cit	y Li
11 Marias Status   12. Was Decoders Ever in U.S.   13. Was Decoders of Piscants of Piscants Circigin? (Specify Yes or No.   14. Race - American Indians, 15. White Decoders (Specify Was or No.   15. Was Decoders (No.   15. Was Decoders (No.   15	Maryland Cecil		North	East							1 ☐ Yes	2[
19. Was Decedent Every on History Corpor (Specify Ves or Now Part Specify Class And Specify Class An	10e. Street and Number			10f. Zip Code	)			10g. C	itizen of	What Co	untry?	
The Name of Content of Description   Specify Cologon (Mexican) Please Plank, etc.   Specify White   Specify	472 Bailiff Road			21901	-			Ţ	Jnite	ed St	tates	
1   New Marriad   20   Married   1   New 1	T. Hallas States	Armed Forces?		3. Was Decedent of	f Hispanic O Jban, Mexica	rigin? (Sp an, Puerto	ecify Yes or No Rican, etc.)	0-				
Specify color in the control of th		If Yes, Give	•							v		
Housekeeping   Health Care	77		160 Do	andontia Haval Oss				100		Wh		
Housekeeping   Health Care	(Specify only highest grade	e completed)	(Gi	ive kind of work don  DO NOT use reti	upation ie <i>during m</i> o red)	st of work	ing	166.	nina of B	usiness/l	indust <b>ry</b>	
17. Father's Name (Fast, Middle, Last)  Elijah J. Bowman  Is Informat's Name/Pleatonship (Type, Pret)  Leonard Ray Kiebler/Son  Leonard Ray Kiebler/Son  Leonard Ray Kiebler/Son  20a. Method of Disposition  I Burla 2 (Commation of Specify)  A Commation of Specify  A Commation of Specify  A Commation of Specify  A Commation of Specify  R.A. Ferris & Co. Inc.  21. Signature of Fast Holland (Specify)  R.A. Ferris & Co. Inc.  22. Name and Advances of Facility  R.A. Ferris & Co. Inc.  23a. Parti. Eriser the disease, or complications that caused the death. Do not enter the mode of drying, such as cardiac or respiratory arrest.  A princy or Town, State & Chester, Pennsylvania  21. Signature of Conditions  A princy or Town State & Chester, Pennsylvania  22. Name and Advances of Facility  R.A. Ferris & Co. Inc.  23b. Parti. Eriser the disease, or complications that caused the death. Do not enter the mode of drying, such as cardiac or respiratory arrest.  Approximate and survey or the state of the stat		College (1-4or 5+	·)					F	lea1+	h Ca	are	
19b. Mailing Address (Streat and Number or Rural Route Number, City or Town, State, Zip Code)  Leonard Ray Kiebler/Son  472 Balliff Road, North East, Maryland 21901  28b. Maind population  1 Baural 2 (Normation 3 Chamoval from State)  1 Baural 2 (Normation 3 Chamoval from State)  1 Baural 2 (Normation 3 Chamoval from State)  1 Baural 2 (Normation 3 Chamoval from State)  1 Baural 2 (Normation 3 Chamoval from State)  1 Baural 2 (Normation 3 Chamoval from State)  20c. Please of Deposition (Name of commercial Service Licensian - City or Town, State 2 Chester -, Pennsylvania  21 Signature of Funeral Service Licensian - City or Town State  22 Name and Address of Facility  1 Baural 2 (Normation 3 Chamoval from State Chester)  23 Part 1 Enfert the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.  24 Department of the Maintenance of Chester of Town State Chester of Cheste				согр		ner's Nam	a (First, Middle	_				
19a. Informant's Name-Relationship (Type, Print)  Leonard Ray Kiebler/Son  29a. Method of Deposition 1 Burial 2 (X Camation 3 Chamoval from State 4 Donation 5 Chine) 29b. Was decident programs and Address of Facility 1 Cause (Final Manual Pour Pour Pour State 1 Canada North East, Maryland 2190) 21. Signally of Funeral Service Licensee  22a. Part Erief the disease, or complications that caused the death. On not enter the mode of dying, such as cardiac or respiratory arrest.  23b. Part: Erief the disease, or complications that caused the death. On not enter the mode of dying, such as cardiac or respiratory arrest.  23c. Part: Erief the disease, or complications that caused the death. On not enter the mode of dying, such as cardiac or respiratory arrest.  23c. Part: Erief the disease, or complications that caused the death. On not enter the mode of dying, such as cardiac or respiratory arrest.  23c. Part: Erief the disease, or complications that caused the death. On not enter the mode of dying, such as cardiac or respiratory arrest.  24c. Part STATIC LUNG CANCER.  25c. Was a consequence off;  25c. Part of the consequence of complete of consequence of consequence of consequence off;  25c. Was a consequence off;  25c. W	Elijah J. Bowman				Vi	da Be	elle Ca	rter	•			
20a. Name and observed of Disposation   Spring of Committee   Spri	19a. Informant's Name/Relationship (Ty	rpe, Print)	19b. Ma	ailing Address (Stre	et and Numi	ber or Run	al Route Numb	er, City	or Town,	State, Z	(ip Code)	_
21. Signature of Funeral Sarvac Licensee  22. Name and Address of Facility.  23. Part Enter the disease, or complications that caused the death. Do not enter the mode of sying, such as cardiac or respiratory arrest. Interval Balvess of Conditions on Street, Elkton, Maryland 2192  23. Part Enter the disease, or complications that caused the death. Do not enter the mode of sying, such as cardiac or respiratory arrest. Approximate interval Balvess of Conditions on Street, Elkton, Maryland 2192  24. Part Enter the disease, or complications that caused the death. Do not enter the mode of sying, such as cardiac or respiratory arrest. Approximate interval Balvess of Conditions on Street, Elkton, Maryland 2192  25. Part Enter the disease, or complications that caused the death. Do not enter the mode of sying, such as cardiac or respiratory arrest. Approximate interval Balvess of Conditions on Street, Elkton, Maryland 2192  26. Due to (or as a consequence of):  27. Mary and the disease, or complications of Conditions on Street, Individual Street, Indi	Leonard Ray Kieb	ler/Son	472	Bailiff	Road,	Nort	h East	, Ma	ary1a	and 2	21901	
21. Signature of Funancial Service Licensee  22. Name and Address of Facility.  22. Name and Address of Facility.  22. Name and Address of Facility.  22. Name and Address of Facility.  22. Name and Address of Facility.  22. Name and Address of Facility.  23. Part. Eries the disease, or complications that caused the death. Do not enter the mode of syling, such as cardac or respiratory arrest.  23. Part. Eries the disease, or complications that caused the death. Do not enter the mode of syling, such as cardac or respiratory arrest.  24. Part. Eries the disease, or complications that caused the death. Do not enter the mode of syling, such as cardac or respiratory arrest.  24. Part. Eries the disease, or complications that caused the death. Do not enter the mode of syling, such as cardac or respiratory arrest.  25. Becumptably list conditions.  26. CHKONLC OBSTRUCTIVE PULNOWANY DISEASE.  27. Many and syling in death of the part 12 mg-many and programmy and p	·		20b. Place of Dis	sposition (Name of	lace)	Apri	Date 23	20c. l	Location -	City or 1	Town, State	
22. Name and Address of Facility Hicks Home for Funerals, P.A. 103 W. Stockton Street, Elkton, Mary and 2192  3a. Part, Enter the desage, or concilications that caused the death. Do not enter the mode of dying, such as cardac or respiratory arrest.  Approximate of Funerals or concilications that caused the death. Do not enter the mode of dying, such as cardac or respiratory arrest.  Approximate of Funerals, P.A. 103 W. Stockton Street, Elkton, Mary and 2192  Approximate of Funerals or concilications that caused the death. Do not enter the mode of dying, such as cardac or respiratory arrest.  Approximate of Funerals or Concentrations of the caused the death. Do not enter the mode of dying, such as cardac or respiratory arrest.  Approximate of Funerals, P.A. 103 W. Stockton Street, Elkton, Mary and 2192  Approximate or Concentrations of the caused the death. Do not enter the mode of dying, such as cardac or respiratory arrest.  Approximate or Concentrations of Concentrati												
23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.  Approximate the cause (Final Internal Behine Int	21. Signature of Funeral Service License	90				ility	1	D .	umoy.	L V CIII.	10	
23a. Part . Eriter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.    Approximate price   Approximate   Approximate   Approximate price   Approximate	1 Marsh	8. Hick	6	HICKS HOT	me for	rune n Sti	erals,	P.A. 1kto	n M	larv1	land 210	วว
IFFEMALE: 23b. Was decedent pregnant in the past 12 moeths?   23c. If yes, outcome of pregnancy i	23a. Part1. Enter the disease, or compli	ications that caused t	he death. Do not e					TICL	7119 1	ICIL Y		16
Due to (or as a consequence of):    CHRANIC OBSTRUCTIVE PULLANAMY DISEASE   Consequence of):	Immediate Cause (Final	ne cause on each line		enter the mode of d	ying, such a	s cardiac					Approximate	
Due to (or as a consequence of):    IFFEMALE   23b. Was decedent pregnant in the past 12 mgeHS?   1   ves 2   low of Unknown   23d. Name and address of person who completed cause of linury at 1   lower of medical vasaminer?   23d. Date of felivery   2   St. Was decedent pregnant in the past 12 mgeHS?   1   ves 2   low of the person with time of death   5   Other (specify)   23d. Date of delivery   Month   Day   Year   1   lower person   23d. Date of delivery   Month   Day   Year   23d. Date of delivery   Month   Day   Month   Day   Year   23d. Date of delivery   Month   Day   23d. Date of delivery   Month   Day   23d. Date of delivery   Month   Day   Month   Day   Year   23d. Date of delivery   Month   Day   Year   23d. Date of delivery   Month   Day   23d. Date of delivery   Month   Day   23d. Date of delivery   Month   Day   23d. Date of delivery   Month   Day   23d. Date of delivery   Month   Day   23d. Date of delivery   Month   Day   23d. Date of delivery   Month   Day   Call   Call   Call   Call   Call   Call   Call   Call   Call   Call   Call   Call   Call   Call   Call   Call		VAC TO SECOND									Onset and D	eat
Due to (or as a consequence of):  d.    IF FEMALE: 23b. Was decedent pregnant in the past 12 mounts?   1   1   1   1   1   1   1   1   1	disease or condition	METAST	TATIC 1								Onset and D	reer eat
Due to (or as a consequence of):   Due to consequence of):   Due to (or as a consequence of):   Due to (or as a consequence of):   Due to (or as a consequence of):   Due to (or as a consequence of):   Due to (or as a consequence of):   Due to (or as a consequence of):   Due to (or as a consequence of):   Due to (or as a consequence of):   Due to (or as a consequence of):   Due to (or as a consequence of):   Due to (or as a consequence of):   Due to (or as a consequence of):   Due to (or as a consequence of):   Due to (or as a consequence of):   Due to (or as a consequence of):   Due to (or as a consequence of):   Due to (or as a consequence of):   Due to (or as a consequ	disease or condition resulting in death)	a KETA ST	Consequence of):	LUNG CI	HUCEL		or respiratory a	arrest,			Onset and D	reer eat
FFEMALE:   23b. Was decedent pregnant in the past 12 mounts?   1   1   1   1   1   1   1   1   1	disease or condition resulting in death)	Due to (or as a	TATIC (consequence of):	LUNG CI	HUCEL		or respiratory a	arrest,			Onset and D	eat
23d. It yes, outcome of pregnancy in the past 12 moeths?   23d. Date of delivery month   23d.	disease or condition resulting in death)  Sequentially list conditions, flany, Lauring to Introductions, cause. Enter Underlying Cause (Disease or injury)	Due to (or as a	TATIC (consequence of):	LUNG CI	HUCEL		or respiratory a	arrest,			Onset and D	reer eat
236. Was decedent pregnant in the past 12 movems?    Company   Com	disease or condition resulting in death)  Sequentially list conditions, and the cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a Due to (or as a	Consequence of):  OBSTA	LUNG CI	HUCEL		or respiratory a	arrest,			Onset and D	reet
236. Was decedent pregnant in the past 12 movems?    Company   Com	disease or condition resulting in death)  Sequentially list conditions, any leaving of introductions cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a Due to (or as a Due to (or as a	Consequence of):  OBSTA	LUNG CI	HUCEL		or respiratory a	arrest,			Onset and D	reer
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.    OSTEOPHY   1   1   1   1   1   1   1   1   1	disease or condition resulting in death)  Sequentially list conditions, Tany, Lawrig to Introdust cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a Due to (or as a Due to (or as a	Consequence of):  OBSTA	LUNG CI	HUCEL		or respiratory a	arrest,			Onset and D	reer
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.    23e. Did tobacco use contribute to the cause of death	disease or condition resulting in death)  Sequentially list conditions, any, leaving to him ediaticase. Enter Underlying Cause, Disease or injury that initiated events resulting in death) Last  IF FEMALE:  23b. Was decedent pregnant	Due to (or as a Due to (or as a Due to (or as a d. Sac. If yes, outcome of	consequence of):  OBSTA- consequence of):	LUNG CA	HUCE/L ULMON		or respiratory a	arrest,			Onset and D	eat
24a. Was an autopsy performed?  25. Was case referred to medical earning and provided to the cause (s) and manner as stated.  26. Place of Death (Check only one)  27. Mannared Death  1 Natural 28a. Date of Injury 28b. Time of Injury 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred  28d. Describe how inju	disease or condition resulting in death)  Sequentially list conditions, Tany, Lauring to Introduct cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 YNo	Due to (or as a Due to (or as a Due to (or as a d. Due to (or a) d. Due to (or a) d. Due to (or a) d. Due to (or a) d. Due to (or a) d. Due to (or a) d. Due to (or a) d. Due to (or a) d. Due to (or a) d. Due to (or a) d. D	consequence of):  OBSTA  consequence of):  f pregnancy  Fetal death	LUNG CA	W CELL		or respiratory a	arrest,			Onset and D	eatl
24a. Was an autopsy performed?  25. Was case referred to medical examiner?  1	disease or condition resulting in death)  Sequentially list conditions.  Tany, Lauri of Uninvolutions, Tany, Lauri of Uninvolutions, Tany, Lauri of Uninvolutions, Tany, Lauri of Uninvolution Cause, (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 moeths?  1  Yes 2  No 9  Unknown	Due to (or as a Due to (or as	consequence of):  OBSTACONSEQUENCE OF):  t pregnancy  Fetal death  me of death	JUNG CA	W CE/L	FANNY	OLS EA	rrest,	Мо	onth	Onset and D	eat
25. Was case referred to medical examiner?  1	disease or condition resulting in death)  Sequentially list conditions, any, leading of introductions, any, leading of introductions, any, leading of introductions, any, leading of introductions. But introductions are sulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  Part II. Other significant conditions conditions conditions.	Due to (or as a Due to (or as	consequence of):  OBSTACONSEQUENCE OF):  t pregnancy  Fetal death  me of death	JUNG CA	W CE/L	FANNY	DISEA	tobacco	Mo use cont	nth tribute to	Very Day Y the cause of de	eat
25. Was case referred to medical examiner?    1   Yes   2   No	disease or condition resulting in death)  Sequentially list conditions, any, leading of introductions, any, leading of introductions, any, leading of introductions, any, leading of introductions. But introductions are sulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  Part II. Other significant conditions conditions conditions.	Due to (or as a Due to (or as	consequence of):  OBSTACONSEQUENCE OF):  t pregnancy  Fetal death  me of death	JUNG CA	W CE/L	FANNY	DISEA	tobacco	Mo use cont	nth tribute to	Very Day Y the cause of de	eat
examiner?    Sexaminer   Sexam	disease or condition resulting in death)  Sequentially list conditions, any, leading of introductions, any, leading of introductions, any, leading of introductions, any, leading of introductions. But introductions are sulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  Part II. Other significant conditions conditions conditions.	Due to (or as a Due to (or as	consequence of):  OBSTACONSEQUENCE OF):  t pregnancy  Fetal death  me of death	JUNG CA	W CE/L	FANNY	DISEA  23e. Did  1   24a. Was	tobacco Yes 2	Mouse cont	onth  tribute to  3  Pro  Were aut	Very Day Y the cause of de	ear
27. Manner of Death 1 Natural 2 Natural 3 Natural 3 Natural 3 Natural 3 Natural 4 Norsing Home 5 Nesidence 6 Other (Specify)  28b. Time of Injury 8 Norsing 1 Norsing Home 5 Nesidence 6 Other (Specify)  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Location (Street and Number or Rural Route Number, City or Town, State)  28d. Location (Street and Number or Rural Route Number, City or Town, State)  28d. Describe how injury occurred  28d. Location (Street and Number or Rural Route Number, City or Town, State)  28d. Describe how injury occurred  28d. Location (Street and Number or Rural Route Number, City or Town, State)  28d. Describe how injury occurred  28d. Location (Street and Number or Rural Route Number, City or Town, State)  28d. Describe how injury occurred  28d. Location (Street and Number or Rural Route Number, City or Town, State)  28d. Describe how injury occurred  28d. Descri	disease or condition resulting in death)  Sequentially list conditions, any, leading of introductions, any, leading of introductions, any, leading of introductions, any, leading of introductions. But introductions are sulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  Part II. Other significant conditions conditions conditions.	Due to (or as a Due to (or as	consequence of):  OBSTACONSEQUENCE OF):  t pregnancy  Fetal death  me of death	JUNG CA	W CE/L	FANNY	23e. Did 1 24a. Was auto	tobacco Yes 2	Mouse cont	onth  inbute to  3  Pro  Were aut prior to co death?	very Day Y the cause of de	ear
28a. Date of Injury 28b. Time of Injury at Work?    Suicide   Could not be determined   Could not be building, etc. (Specify)	disease or condition resulting in death)  Sequentially list conditions, and, having Julian additions, and, having Julian additions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or as a Due to (or as	consequence of):  OBSTACONSEQUENCE OF):  f pregnancy Fetal death me of death	JUNG CA	CL MON	FANN	23e. Did 1 24a. Was auto	tobacco Yes 2	Mouse cont	onth  inbute to  3  Pro  Were aut prior to co death?	very Day Y the cause of de	ear
29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)  APAIL 2A, 2005  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	disease or condition resulting in death)  Sequentially list conditions.  Jary, Lauring to Introductions cause. Enter Underlying Cause, (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 moeths?  1	Due to (or as a complete to the complete to th	consequence of):  OBSTA- consequence of):  f pregnancy	JUNG CA	26. Plac	I.	23e. Did 1 24a. Was auto perfit 1 Yes h (Check only me 5 Res	tobacco Yes 2 an prey promed? 2 None) idence	Mo use cont 2 No 24b.	were aut	very Day  the cause of de bably 4 U  topsy findings a	ear
288. Place of Injury - At home, tarm, street, factory, office  29a. Certifier (Check only one)  29b. Signature and title of certifier  29c. License number  29c. License number  29c. License number  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	disease or condition resulting in death)  Sequentially list conditions, fairly, Lauring to Introductions, Cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown  Part II. Other significant conditions core  OSTEO ANTILLIES  25. Was case referred to medical examiner? 1  Yes 2 No 1	Due to (or as a complete to co	consequence of):  OBSTA  consequence of):  f pregnancy	3 Ectopic pregnar 5 Other (specify) e underlying cause of the control of the cont	26. Place	Le of Deat	23e. Did 1 24a. Was auto perfit 1 Yes h (Check only me 5 Res	tobacco Yes 2 an prey promed? 2 None) idence	Mo use cont 2 No 24b.	were aut	very Day  the cause of de bably 4 U  topsy findings a	ear nath nkn
(Check only one)  2   Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)  APRIL 22, 2005  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	disease or condition resulting in death)  Sequentially list conditions, and, Lauring John Market Cause. Enter Underlying Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or as a complete to the state of Injury (Month, Day)	consequence of):  OBSTA  consequence of):  f pregnancy	JUNG CA	26. Place Dither: 4 N	Le of Deat	23e. Did 1 24a. Was auto perfit 1 Yes h (Check only me 5 Res 28d. Describe	tobacco Yes 2 san psy 2 N one) idence how inju	Mo use cont 2 No 24b.	were autoprior to codeath?  1 Yes  er (Specified)	very Day Y the cause of de obably 4 U topsy findings a completion of ca	ear math
(Check only one)  2   Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)  APRIL 22, 2005  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	disease or condition resulting in death)  Sequentially list conditions.  Jary, Lauri of Unincodist cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 moeths? 1   Yes 2   No 9   Unknown  Part II. Other significant conditions core	Due to (or as a composition of the composition of t	consequence of):  OBSTA- consequence of):  f pregnancy	JUNG CA	26. Place Dither: 4 N	Le of Deat	23e. Did 1 24a. Was auto perful 1 Yes h (Check only me 5 Res 28d. Describe	tobacco Yes 2 s an psy ormed 2 2 No	Mo use cont 2 No 24b.	were autoprior to codeath?  1 Yes  er (Specified)	very Day Y the cause of de obably 4 U topsy findings a completion of ca	eath nath nath vail
29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)  APRIL 22, 2005  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	disease or condition resulting in death)  Sequentially list conditions, and, Lauring John Moderlying Cause, (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or as a complete to the state of language)  Due to (or as a co	consequence of):  OBSTA- Consequence of):  t pregnancy Fetal death me of death  not resulting in the  t 2 ER/Outpat (Year)  28b. Time Injun y - At home, farm, (Specify)	JUNG CA	26. Place Other: 4 \( \) I ves 2 \( \)	I. I. Le of Deat	23e. Did 1 24a. Was auto perf. 1 Yes h (Check only me 5 Res 28d. Describe 28f. Location of City or To	tobacco Yes 2 i an promed? 2 None) idence how inju	Mo use cont 2 No 24b. 6 Soth ury occurrent	onth  aribute to  a Pro  Were aut prior to codeath?  aribute (Special Special	very Day Y the cause of de bably 4 Du topsy findings a completion of ca 2 No	eath nath nath vail
DOOHTILL AA, 2005  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	disease or condition resulting in death)  Sequentially list conditions, and, Lauring to humodisticause. Enter Underlying Cause, (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown  Part II. Other significant conditions conditions conditions conditions conditions are significant conditions.  25. Was case referred to medical examiner? 1   Yes 2   No   House the conditions conditions conditions conditions conditions conditions.	Due to (or as a Due to (or as	consequence of):  OBSTA- consequence of):  f pregnancy	3 Ectopic pregnar 5 Other (specify) a underlying cause of the course of	26. Place Dither: 4 N	Lee of Deathursing Ho	23e. Did 1 24a. Was auto perfuly es to the control of the control	tobacco Yes 2 an psy orned 2 ZIN one) idence how inju	Mo use cont 2 No 24b. 1	were autoprior to codeath?  The reference of the referenc	very Day Y the cause of de obably 4 U topsy findings a completion of ca	eath nath nath vail
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	disease or condition resulting in death)  Sequentially list conditions, and, Lading John Modern Cause. Enter Underlying Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or as a Due to (or as	consequence of):  OBSTA- consequence of):  f pregnancy	JUNG CA	26. Place Dether: 4 New York?  Yes 2 e  time, date a y opinion, de	the of Deat	23e. Did 1 24a. Was auto perfuly es to the control of the control	tobacco Yes 2 s an psy orned? 2 No one) idence how injut cause(s date an	Mo use cont 2 No 24b. 6 Sth ury occur and Numb te) s) and mand place,	were autoprior to codeath?  The reference of the referenc	very Day Y the cause of de phably 4 Du lopsy findings a completion of cause of the	eath nath nath vail
	disease or condition resulting in death)  Sequentially list conditions, any, leaving of himself to cause. Enter Underlying Cause, Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   Yho 9   Unknown  Part II. Other significant conditions condit	Due to (or as a Due to (or as	consequence of):  OBSTA- consequence of):  f pregnancy	Buctive P  3 Ectopic pregnar 5 Other (specify)  a underlying cause of the course of th	26. Place Other: 4 N  I Ves 2 Services  time, date a consenumber	I	23e. Did 1 24a. Was auto perfuly es to the control of the control	tobacco Yes 2 s an psy orned? 2 No one) idence how injut cause(s date ar 29d. D.	Mo use cont 2 No 24b. 6 Sth ury occur and Numb te) s) and mand place, ate signer	were autroprior to codeath?  The ref (Special Control	very Day Y the cause of de phably 4 U topsy findings a completion of ca 2 No ral Route Numb stated. to the cause(s)	eath nath nath vail
1 1 2 PRO 1 1 1 TOTAL P. D COM C. O. D. MOTOTI. S.A	disease or condition resulting in death)  Sequentially list conditions, Tany, Lawry of Introductions,	Due to (or as a Due to (or as	consequence of):  OBSTA- consequence of):  f pregnancy Festal death ime of death anot resulting in the  t 2 ER/Outpat (Year) 28b. Time Injury - At home, farm, (Specify)  Ty - At home, farm, (Specify)	JUNG CA	26. Place Other: 4 N  I Ves 2 Services  time, date a consenumber	I	23e. Did 1 24a. Was auto perfuly es to the control of the control	tobacco Yes 2 s an psy orned? 2 No one) idence how injut cause(s date ar 29d. D.	Mo use cont 2 No 24b. 6 Sth ury occur and Numb te) s) and mand place, ate signer	were autroprior to codeath?  The ref (Special Control	very Day Y the cause of de phably 4 U topsy findings a completion of ca 2 No ral Route Numb stated. to the cause(s)	ear math

Registrar

3

			1 - For State Registrar	State of Marylan		rtmen tificate			nd M	_	giene Reg. No.	2008		64
	Physici		1. Decedent's Name (First, Middle, Last) Maria F. Carroll							2. Date of De Month April	Day	, 2005	3. Time of I	
	/Medic Examin	er	4a. Facility Name (If not institution, give s Manor Care Potomac	treet and number)			Town, or L	ocation of			4c.	County of D	eath	
	Funeral Director		011-20-9733	м ж F 7. Age (In yrs.	(a <i>st birthd</i> ay) Yrs.	If Under Months	1 Year Days	If Under 2 Hours	Min.	8. Date of Bir (Month, Da	y, Year)		Birthplace (State or Country)	Foreign
	Aaryland f show	ō	Usual Residence of Decedent  10a. State  10b. County  Maryland Montgomer		y, Town or Lo	cation						10d. Inside City Limits		
	or 28a-	Funeral Directo	10e. Street and Number			10f. Zip					•	zen of What	,	
	s 23e	rai	10714 Potomac Tenni		0 100		854					ted St		
036	ours after de of, or item Examinar r	by	11. Marital Status  Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		Yas Deced f Yes, spec		Specify:	in / (Spe , Puerto F	cify Yes or No Rican, etc.)	-	Black, W	merican Indian, hite, etc. White	
21215-0036	be filed within 72 hours after deeth with the Maryland ital Hyglene. Id other then "natural", or items 23e or 28e-f show event, the Medical Examinating mast be notified at	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)		16a. Deced (Give life. L Profe	kind of wor DO NOT us	rk done du	ion ring most	of workin	g		nd of Busine ducati		
Maryland 21	0 = 0 ×	To Be C	17. Father's Name (First, Middle, Last) Timothy J. Carrol]	L			1	18. Mother Fran	-	(First, Middle, a Qui	Maiden none:			_
	and 2 should ealth and Men n 27 is marke		19a. Informant's Name/Relationship (Type Rev. Msgr. Leonard		P.O.	g Address Box	(Street ar 29206	Was	r or Rural hing	Route Number ton, D	er, City o. •C•	7 Town, State 20017	e, Zip Code) -0206	
altimore,	permit. Pages 1 and 2 should b Department of Health and Ments Importent: If item 27 is marked any injury or other traumatic and one.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State Geo	lace of Dispo emetery, cren rgetown ical Ce	n Uni	ther place. Versi	ty A	pril 200				or Town, State	
Balt	permit. Departr Importe any inju		23. Signature of uneral Service Linense				d Address	of Facility	Colu	mbia M	ortu ashi	ary Se ngton,	rvices, D.C. 20	Inc. 037
	Physician		23a. Part 1. Enter the disease, or complic shock, or heart failure. List only on Immediate Cause (Final disease or condition	cations that caused the deather cause on each line.						respiratory a	rrest,		Approximate Interval Betw Onset and D	reen
	/Medical Examiner		resulting in death)	Due to (or as a conseq	uence of):	7								
,0	icate be executed physician and sthe burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	uence of):										
8760,	physic the bu	dica	•											
P.O. Box 6	ath certif ttending or use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	Ectopic pro					23d. Date of delivery Month Day			ear		
	ires that the de signed by the a d be detached t	by	Part II. Other significant conditions con	tributing to death but not res	ulting in the ur	nderlying ca	ause giver	in Part I.			obacco u Yes 2(		to the cause of de	eath?
Vital Records,	sician: The law requir s certificate has been si lirector, page 2 should b	Completed								24a. Was autor perfo		24b. Were prior death		vailable use of
ita	cian: ertifice actor, I	Bec	25. Was case referred to medical examiner?							(Check only o	one)			
ō	Attending Physician: In death. ector: After this certifies by the funeral director, I	ion: To	27. Manner of Death 1-Natural 5 Pending	ospital: 1 Inpatient 2 Inpatie	28b. Time of Injury	2	8c. Injury a Work?	at Nur	2	Bd. Describe			pecify)	
Division	I or Attend after death Director:	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	ome, farm, str	M eet, factory		es 2□N			ion (Street and Number or Rural Route Number, r Town, State)				
	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: Alter this certific completely filled in by the funeral director.	edical Co	29a. Certifier 1 Certifying Phys (Check only 2 Medicel Examinone)	sicien: To the best of my knoner: On the basis of examina and manner stated.	wledge, death tion and/or inv	occurred a	at the time	, date and nion, deat	d place, a h occurre	nd due to the d at the time,	the cause(s) and manner as stated. me, date and place, and due to the cause(s)			
	To th To th comp	Me	29b. Signature and title of certifiers			-	License		11			,	onth, Day, Year)	
,	V		30. Name and address of person who co	moleted cause of death (Item	1 23a) (Type	Print)	000	フィラ	66		4	12/0		
			Sun tea Bhoga	10.	A 200	1L X	ogra	Ros	ud.	Sech.	230	TOW	Sow Hn	Li286
	Sta Regist		31. Date filed (Month, Day, Year)  APR 1 3 200	32 Registrar's Signa	ture dos	all?							·	

			For State	State of Marylar				Mental Hy	giene	005	1.1.65		
			Registrar  1. Decedent's Name (First, Middle, La			rtificate	of Death	2. Date of De.	Reg. No.=	000	3. Time of Death	_	
	Physicia /Medic		CHONG HU	ii CHOE	>			Month April	Day 11. 20	Year 105	2:55 PM <sup>M</sup>		
Ì	Examin		4a. Facility Name (If not institution, gire			4b. City, To	vn, or Location of Dea	th	4c. Co	unty of Death			
	-		Washington Advent 5. Social Security Number 6.	ist Hospital Sex 7. Age (In yrs.	last birthday)	Takoma If Under 1 Y		8. Date of Bird		tgomer	*		
	Funeral Director			1□M 2 <b>X</b> F 77	Yrs.	Months D	ays Hours Min		y, Year)	7 Kor	place (State or Foreign intry) :ea		
	and w		Usual Residence of Decedent  10a. State 10b. County	10c. Ci	ty, Town or Lo	ocation					10d. Inside City Limits	_	
	Maryli -f eho	tor	Maryland Montgom		ver Sp						1 ☐ Yes 2X No		
	th the	Funeral Directo	10e. Street and Number	ery	ver ph	10f. Zip Co	de		10g. Citizer	n of What Cou	intry?	_	
	s 23a	rai	440 University Bl			2090				d Stat			
	fter de r Item	Fune	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☒ No	.S. 13.	Was Deceden If Yes, specify	of Hispanic Origin? (S Cuban, Mexican, Puer	Specify Yes or No rto Rican, etc.)	14.	Race - Ameri Black, White			
99	rel', o	by	3 Widowed 4 Divorced	If Yes, Give XX Year or Dates:		1□Yes 2【X	No Specify:		Sp	ecify:	ian		
21215-0036	filed within 72 hours after death with the Maryland Hygiene. other than "neturel", or Items 23a or 28a-f ehow oth, I're Modical Examiner must be malified at	Completed	15. Decedent's E (Specify only highest gi	ducation ade completed)	(Give	dent's Usual C kind of work of DO NOT use r	lone during most of wo	orking	16b. Kind	of Business/Ir	ndustry		
212	yene.	omp	Elementary/Secondary (0-12)	College (1-4or 5+)		Maker	alired)		Own H	Home			
g	al Hyg I other	Be C	17. Father's Name (First, Middle, Las	t)	110mo	TACTOL	18. Mother's Na	me (First, Middle,					
<u>Y</u> a	should be nd Mental marked c	To	Hyun Shin	<u> </u>	1		Soon Ki				-	_	
Maryland	id 2 sh th and th and traum		19a. Informant's Name/Relationship			ng Address <i>(S</i> <b>Farmha</b> i	reet and Number or R	stow, VA			p Code)		
re,	s 1 and of Health item 27 other tr		Chong Cho1 Choe / 20a. Method of Disposition	20b. I	Place of Dispe	osition (Name	of .	Date 14,		tion - City or T	own, State		
Ē	Pages ment of l ant: If its ury or o	1	1 X Burial 2 ☐ Cremation 3 ☐ 1 4 ☐ Donation 5 ☐ Other (Spec	XRemoval from State   Far	irfax N neterv	matory or othe Memoria	1 Park 200		Fairfa	ax, Vir	ginia		
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importants: If item 27 is marked other than "neturel; or Items 23a or 28a-f ehow among injury or other traumatic event, If a Modical Examinet must be notified at once.		21. Signature of Funeral Service Lice				ddress of Facility Memorial F	uneral H	ome				
			23a. Part1. Enter the disease, or cor	M00956  mplications that caused the dea			Memorial F ddock Road f dying, such as cardia			ginia	Approximate	_	
200	Physician		shock, or heart failure. List only Immediate Cause (Final disease or condition	y one cause on each line.	1 e	in ceph	alopath	4			Interval Between Onset and Death		
	/Medical Examiner		resulting in death)	Due to (or as a consec		0 ( 00 )		0			. c voge		
	Examine.	PL	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a consec	uence of):								
	cuted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	Ç	,								
Ö,	ate be executed hysician and the burial-transit	i Exe	resulting in death) Last	Due to (or as a consec	quence of):								
8760,	icate be executed physician and s the burial-transit	Physician/Medical	•	d								_	
Box 6	death certific e attending p ed for use as f	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregn		70			23d	d. Date of deliv	/ery		
.O. B		sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 □ Live birth 2 □ Feta 4 □ Pregnant at time of a 9 □ Unknown		⊒Ectopic pregi ⊒ Other (s <i>peci</i>				Month	Day Year		
<u>α</u>	by by		9 Unknown  Part II. Other significant conditions	contributing to death but not re-	sulting in the u	underlying caus	e given in Part I.	23e. Did t	obacco use	contribute to	the cause of death?	-	
rds,	quires tha n signed ald be del	d by	Liver	cimnosis				10	Yes 2	vo 3 □ Pro	bably 4 Unknown		
SCOI	e law requir has been si je 2 should l	Completed						24a. Was			opsy findings available		
Ä		Com							2 No	death?	ompletion of cause of 2 No		
Vita	Physicien: Th this certificate ral director, pag	o Be	25. Was case referred to medical examiner?	Hospital:			Cthora	eath (Check only o					
of	g Phys er this eral dii	-	1 ☐ Yes 2 ☑ No 27. Manner of Death	Hospital: 1 Inpatient 2 [ 28a. Date of Injury (Month, Day Year)	28b. Time o	nt 3□ DOA of 28c.	Injury at	Home 5 Resi			(fy)	=	
sion	Attending F r death. sctor: After by the funer	atio	1 Natural 5 Pending 2 Accident investigati	on	Injury	М	Work? 1 ☐ Yes 2 ☐ No						
Division of Vital Records,	l or Attendater deall Director:	ertification;	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	d 28e. Place of Injury - At h building, etc. (Speci	iome, farm, st fy)	reet, factory, o	ffice		(Street and Number or Rural Route Number, own, State)				
_	To the Hospitel or Attending Phwithin 24 hours after death. To the Funeral Director: Atter th completely filled in by the funeral	edical C	29a. Certifier 1 Certifying F	Physician: To the best of my kn	the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  e basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ca								
	To the H within 24 To the F complete	Medi	one)  29b. Signature and title of certifier	and manner stated.	ation and or ii		icense number	artio artio (iii)		signed (Month			
)			→ ()(C)	Cwm. 17	10.	1	)-309:	27			-, 2005		
۲	2		30. Name and address of person who		т 23а) (Турв								
			31. Date filed (Month, Day, Year)	M.U. 103	134	Corgi	a Huenu	7 2001,	31100	7 > 7 1	8 110 700/9	:2	
	Sta Regist		APR 1 3 20	2. Registrar's Sign	A COS	Le							

		1	For State Registra/WEND#12per				irtment of H		d Menta		ene g. N&2 () ()	5	14466		
			Decedent's Name (First, Middle							te of Death	Day Year				
	Physicia /Medic	al				OLE				RIL					
	Examin		4a. Facility Name (If not institution		mber)			n, or Location of Death			4c. County o		n CEC		
			6905 21st  5. Social Security Number	AVE 6. Sex	7. Age (In yrs.	last birthday)	HYATT If Under 1 Year	SVILLE If Under 24 h	Hrs. 8. Da	te of Birth	PRINCE	9. Birthpl	ace (State or Foreign		
	Funeral Director		458-07-4006	1 <b>½</b> M 2□F	86		Months Days	Hours N	Ain (M)	onth Dav.	, 1919	Count	TUCKY		
			Usual Residence of Decedent									140			
	show	.	10a. State 10b. County		10c. C	ty, Town or Lo	cation					10	od. Inside City Limits  17☐ Yes 2 ☐ No		
	Ba-f s	Director		GEORGES		НҮА	TTSVILLE			10	g. Citizen of W	hat Count			
	with th	훕	10e. Street and Number				10f. Zip Code	700		"					
	eath	Funerai	6905 21st	12. Was Dec	edent Ever in Uorces?[937–	4S. 40 13. V	207 Was Decedent of H	ispanic Origin	? (Specify Y	es or No-	14. Race				
(0	72 hours after death with the Maryland naturel, or Items 23e or 28e-f show disal Examination coulified at		1 ☐ Never Married 2 XMar	ned 1 XYes	2 No 1944	1-1962	fYes, specify Cuba	an, Mexican, Pi Specify:	uerto Hican,	etc.)		, White, e	etc.		
21215-0036	ours a	by	3 Widowed 4 Divorced	If Yes, Gi Year or D	oates: 195	8	1⊡Yes 2 <b>x</b> No				Specify:	WHI			
5	72 h 'natu	Completed		it's Education st grade completed)		(Give	dent's Usual Occup kind of work done DO NOT use retired	during most of	working		16b. Kind of Bus	iness/Ind	lustry		
121	within ene. then "	mp	Elementary/Secondary (0-12)	College (	1-4or 5+)	111-0. 1	DEFENSI	,			U.S.	ARM	7		
Q 2	Hygie Hygie ther ant, II		12 17. Father's Name (First, Middle,	Last)			DEFENDI		Name (First	, Middle, N	faiden Sumame				
Maryland	s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hygene. It has the marked other treat "naturel", or Items 23a or 28a-f show them 27 is marked other then "naturel", or Items 23a or 28a-f show other treatment ovent, the Madical Examina must be notified at	To Be	ROBERT	FULTON	COLE				MAHAI	LLIE	JANE .	JOHN:	SON		
ary	should and Men s marke numatic		19a. Informant's Name/Relations	ship (Type, Print)		19b. Mailir	ng Address (Street	and Number o	or Rural Roul	te Number,	City or Town, S	State, Zip	Code)		
	1 and 2 Health a lem 27 is		SACHIKO M. CO	LE/WIFE		6905	_	AVE., H	YATTS <sup>1</sup> Date		MD. 2000. Location - 0		um Stata		
Baltimore,			20a. Method of Disposition 1 □ Burial 2 ▼Cremation	3 □Removal from	1	cemetery, crei	sition (Name of matory or other plac					•			
tim	t. Pa rtmen rtent: njury		1   Burial 2   Cremation 3   Removal from State 4   Donation 5   Other (Specify)   CHAMBERS CREMATORY   4-13						13, 20	005 _	RIVERD	ALE,	MD.		
Bal	Depar Impor any ir	h	21. Signature of Funeral Service	ramber		00091 C	HAMBERS 1 801 CLEVI	FUNERAL ELAND A	VE.,	RIVER	DALE, M	UM, P. D. 20	737		
			23a. Part1. Enter the disease, o shock, or heart failure. Lis	r complications that t only one cause on	caused the dea each line.	ith. Do not ent	er the mode of dyir	ng, such as car	rdiac or resp	iratory arre	est,		Approximate Interval Between Onset and Death		
	Physician		Immediate Cause (Final disease or condition	a. CHRO	NIC OBS	STRUCTI	VE PULMOI	NARY DI	SEASE						
	/Medical Examiner		resulting in death)	Due to	(or as a conse	quence of):									
		Į.	Sequentially list conditions, if any, leading to immediate	b. — Due to	(or as a conse	quence of):									
	uted	Examine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	<b>1</b>											
ó	be executed sician and burial-transit		resulting in death) Last	quence of):											
8760,	ate be physicia the bu	dicai		d											
9	ntifica ing ph e as th	Med	IF FEMALE:	00 1/											
Вох	death certificate be executed e attending physician and nd for use as the burial-transit	Physician/Me	23b. Was decedent pregnant in the past 12 months?	1 Live	utcome of pregue birth 2 Per gnant at time of	tal death 3	Ectopic pregnanc	у			23d. Date Mor	e of delive hth	Day Year		
0.	at the de by the a tached f	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unk		death 51	Other (specify) _								
ط	The law requires that the tte has been signed by the bage 2 should be detache		Part II. Other significant condit	ions contributing to	death but not re	sulting in the u	inderlying cause giv	ven in Part I.	2	23e. Did tol	oacco use contr	ibute to th	ne cause of death?		
Records,	uires n sign lid be	d by							_ 1	1 □ Ye	s 2 No	3 🗌 Prob	ably 4 Minknown		
00	tw require s been sig	Completed							2	4a. Was a		Vere auto	psy findings available mpletion of cause of		
Re	The lav	mo							1	perforr	ned? d	eath?	2 🗆 No		
Vital	ysicien: The is certificate hadirector, page	Be C	25. Was case referred to medic examiner?					26. Place of	f Deatn (Che	eck only on	8)				
of V	Physicien: this certific ral director,	မ	1 ☐ Yes 2 🗶 No			ER/Outpatie	III 3 DOA				ence 6 Othe		y)		
no	ding Phy th. : After thi : funeral o	ion;	27. Manner of Death 1 ▼Natural 5 □ Pend	mig	e of Injury onth, Day Year)	28b. Time o Injury	Wo	ryat rk? ]Yes 2 □ No		Jeschbe III	ow injury occurr	<b>5</b> 4			
Division	or Attending after death. Director: After in by the fune	icat	3 ☐ Suicide 6 ☐ Could	tigation I not be 28e, Plan	ce of Injury - At	home, farm, st	reet, factory, office		28f. L		(Street and Number or Rural Route Number,				
Di∨	in Sit e	Certification;	4  Homicide deter	mined 289. Plat	ding, etc. (Spe	cify)				City or Towi	n, State)				
	To the Hospitel or Attenwithin 24 hours after deal To the Funerel Director: completely filled in by the	Medical C	29a. Certifier 1 Certify (Check only one)	ing Physician: To the	ne best of my ki basis of exami	nowledge, dea nation and/or in	th occurred at the to	ime, date and popinion, death	place, and d occurred at	ue to the c the time, d	ause(s) and ma ate and place, a	nner as s and due to	tated. o the cause(s)		
	o the ithin i	Mec	29b. Signature and title of certif		stated.		29c. Licen	se number		2	9d. Date signed	(Month,	Day, Year)		
	⊢ ≯ ⊢ ŏ		mant	Que	Je w		D	23743			APRT	L 13	, 2005		
1.	+ +1		30. Name and address of perso	n who completed ca	use of death (It		, Print)								
				rz, M.D.	7525		WAY CENT	ER DR.,	GREE	NBELT	, MD. 2	0770			
	St Regist	ate rar	31. Date filed (Month, Day, Yea APR 1	3 2005	Registrar's Sig	nature A	adi								

			For State Registrar	State of Marylar	•	artment of H			ene	F 11.1.67	
	Physici	an	1. Decedent's Name (First, Middle, Last)					2. Date of Death Month	the latest	3. Time of Death	_
	Physici: /Medic		JEANETT		COLLIE			APRIL	11, 20	05 10:25 A M	1
	Examin	er	4a. Facility Name (If not institution, give st			4b. City, Town, o			4c. County		
	Funeral		23505 LOG HOUSE  5. Social Security Number 6. Sex		last birthday)	If Under 1 Year	If Under 24 Hrs	8. Date of Birth		TGOMERY  9. Birthplace (State or Foreign	
	Funeral Director		,	M 2 <b>X</b> F 75	Yrs.	Months Days	Hours Min	APR . 20	1929	9. Birthplace (State or Foreign Country) VIRGINIA	
<u> </u>	p ,		Usual Residence of Decedent	100 6	ty. Town or Lo	antina				dod lasida O'h Linia	_
	shov	ក	10a. State 10b. County							10d. Inside City Limits 1 XYes 2 □ No	
	the N	ect	MD. MONTGOMER  10e. Street and Number	LY	GAL	THERSBURG	<del>;</del>	10	g. Citizen of W		_
	3a or	ā	23505 LOG HOUS	E RD.		208	182		U.S		
	filed within 72 hours after death with the Maryland Hygiene. uther than "natural", or Itams 23a or 28a-f show uth, the Medical Examination Locilited at	nera		Was Decedent Ever in U     Armed Forces?			lispanic Origin? (	Specify Yes or No-	14. Race	- American Indian,	
9	or Its	Y Fu	1 Never Married 2 Married	1 Tes 2 Tho		1 ☐ Yes 2 ဩ <b>Y</b> No	Specify:	nto ritioan, otc.)	Specify	k, White, etc.	
Ö	hours lural',	d by	3 Widowed 4 Divorced	Year or Dates:						WHITE	
5	in 72	Completed	15. Decedent's Educ (Specify only highest grade	completed)	(Give	dent's Usual Occup kind of work done DO NOT use retired	during most of wo	orking	ISD. KING OF BU	siness/Industry	
212	r than	mo	Elementary/Secondary (0-12)	College (1-4or 5+)		HOMEMAK	ŒR		]	HOME	
Maryland 21215-0036	al Hyg	Bec	17. Father's Name (First, Middle, Last)				18. Mother's Na	me (First, Middle, M	laiden Sumam	е)	
<u>ya</u>	Duld b Ments arkac atic e	2		ARD PILLOW			MAI		GINIA	COFER	
Nar	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or items 23a or 28a-1 show any injury or plant traumatic event, the Medical Examination must be notified at once.		19a. Informant's Name/Relationship (Typ		7/			Pural Route Number,			
e) O	1 and Healt am 2		REBECCA LOWE/DA  20a. Method of Disposition	20b. I	Place of Dispo	sition (Name of		GAITHERS Date		D. ZU88Z City or Town, State	-
nor	ages it: # it		1 ☐ Burial 2 TCremation 3 ☐ Re '4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	cemetery, crer	natory or other plac					
altimore,	nit. Partme ortan injur		21. Signature of Funeral Service Licenses		22	CREMATOR 2. Name and Addre	ss of Facility	3–2005		ALE, MD.	_
m	Den Person		> AlAl Chame	respect MOO	091   Cl	HAMBERS F 801 CLEVE	TUNERAL I ELAND AVI	HOME & CRI	MATORI DALE, M	UM,P.A. D. 20737	
	rnysician /Medical Examiner		23a. Part1. Enter the disease, or complic shock, or heart failure. List only one immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions.	e cause on each line.  Due to (or as a consec	Panc quence of):	er the mode of dyin			st,	Approximate Interval Batween Onset and Death	
8760,	icate be executed physician and s the burial-transit	dical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c. resulting in death) Last	Due to (or as a consec							
.O. Box 6	The law requires that the death certific ite has been signed by the attending p page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 V No 9 □ Unknown	3c. If yes, outcome of pregn 1 Live birth 2 Fet 4 Pregnant at time of o	aldeath 3 [	Ectopic pregnancy Other (specify)	у		23d. Date Mor	e of delivery hth Day Year	
<u>α</u>	uires that i signed by Id be deta	by	Part II. Other significant conditions conf	tributing to death but not re-	sulting in the u	nderlying cause giv	ven in Part I.			ibute to the cause of death? 3 ☐ Probably 4 ☐ Unknown	n
Vital Records,	ie law requir has been si ge 2 should l	Completed						24a. Was ar autopsy perform	/ p	Vere autopsy findings available prior to completion of cause of leath?	e
a		e Co	25. Was case referred to medical				00 Pl 4 P-			Yes 2 No	
		0 B	examiner?	ospital: 1   Inpatient 2	ER/Outpatier	nt 3 DOA Oth		eath <i>(Check only one</i> Home 5 Reside		er (Specify)	_
on of	ding After fune	tlon; T	27. Manner of Death  1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	f 28c. injur Wor	ry at	28d. Describe ho			
Division	in Dir	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Speci	nome, farm, sti ify)	reet, factory, office		28f. Location (Str City or Town		er or Rural Route Number,	
	e Hospital 24 hours a te Funaral i letely filled	edical	29a. Certifier 1. Certifying Phys (Check only 2 Medical Examin one)	sician: To the best of my kn ner: On the basis of examin and manner stated.	owledge, deat ation and/or in	h occurred at the til vestigation, in my o	me, date and place opinion, death occ	e, and due to the ca curred at the time, da	use(s) and mai ite and place, a	nner as stated. and due to the cause(s)	
	To the within To the Comp	Me	29b. Signature and title of certifier	1		29c. Licens	se number	29	d. Date signed	(Month, Day, Year)	
	2		· CO	4		Do	0605	26 A JAFRI	April	11 2005	
			30. Name and address of person who con	mpleted cause of death (Ite			AYESHY	7 JAFRI 2 Pock	, M.D.	MD 26850	
	St: Regist	ate	31. Date filed (Month, Day, Year) APR 1 3 200	3. Registrar's Sign		de					

			For State	State of Mary	•	artment of H			2111	15	and the state of t	6.8
		-	Registrar  1. Decedent's Name (First, Middle, Last)	)		inioato or i		2. Date of Death	Reg. No 2. Date of Death			
	Physici		NORMA	N	CHAIKIN			APRIL 1	Day 1 . 2005	Year	10:30	РМ
	/Medic Examin		4e. Fecility Name (If not institution, give		0	4b. City, Town, or	r Location of Dea		4c. County		20.30	
	CAGIIIII		HEBREW HOME OF GRE	EATER WASHI	NGTON	ROCKVII	LLE		MONTO	MONTGOMERY		
	Funeral		Social Security Number     6. Security Number	TM 6075	yrs. last birthday,	If Under 1 Year Months Days	If Under 24 Hrs Hours Min		Year)	9. Birthplace (State or Foreig Country) 924 MARYLAND		
	Director		3,0 22 3320 2	<sup>M 2□ F</sup> 80	Yrs.			JUNE 5,	1924 M	IARYL	AND	
	and w		Usual Residence of Decedent  10a. State 10b. County	10	c. City, Town or L	ocation				1	0d. Inside Cit	ty Limits
	Manyl f sho	ō	MARYLAND MONTGOME	RV	SILVER	SPRING					1 🗆 Yes	2 No
	ith the Marylan or 28a-f show	Director	10e. Street and Number	7201	DIDVIK	10f. Zip Code		10	g. Citizen of W	hat Coun	itry?	
	death with the Maryland rms 23a or 28a-f show		1111 UNIVERSITY BI	LVD., WEST	#1208	20902		U	NITED S	TATE	S	
	deat	Funeral	11. Marital Status	12. Was Decedent Ever Armed Forces?	r in U.S. 13.	Was Decedent of H	lispanic Origin? (	Specify Yes or No-		- Americ	an Indian,	
õ	or items		1 Never Married 2 Married	1 ☐ Yes 2 X No If Yes, Give		1 ☐ Yes 2X No	Specify:	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	Specify:			
2-003p	I within 72 hours after death with the Maryla tiben. than "natural", or items 23e or 28e-f shov Its Medical Examinar mast be restified at	d by	3 Widowed 4 Divorced	Year or Dates:	16a Dasa			1 4		WH	ITE	
	n 72 n *nat	Completed	15. Decedent's Edu (Specify only highest grad	e completed)	(Give	dent's Usual Occup kind of work done of DO NOT use retired	during most of we	orking	6b. Kind of Bu	siness/inc	lustry	
7	within iene. r than "	mo	Elementary/Secondary (0-12)	College (1-4or 5+)		NER			FOOD			
0	Hyg othe	0	17. Father's Name (First, Middle, Last)				18. Mother's Na	ame (First, Middle, M	aiden Sumame	a)		
land	uld be Aental rked c	To B	SIMON	CHAIKIN			FLORE	NCE R	JBINSTE	IN		
a	2 should be and Mental is marked aumatic ev	i	19a. Informant's Name/Relationship (Ty	pe, Print)				Rural Route Number,				
≥,	and ealth m 27 her tr		HARRIET CHAIKIN,	WIFE		100	TY BLVD.	, WEST #12				, MD
ore ore	To Fig.		20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □ F	Removal from State		matory or other plac	· I		Dc. Location - (			
	t. Pa rtmen rtant:		* 4 □ Dopation 5 □ Other (Specify)  21. Sign ture of un val Service Uceps			EMORIAL G			LNEY, N			
Balt	permit. Pages 1 and 2 should be Department of Health and Mental Important: If item 27 is marked any injury or other traumatic events.		21. Signature of direct diseases	Ami	D	ANZANSKY –	ĞÖLDBERG	MEMORIAL	CHAPEL	S, I	NC.	
9	余		23a. Part . Enter the disease, or compl	ications that caused the				E, ROCKVI  ac or respiratory arres		20	Approximate	
	Physician		shock, or heart failure) List only or Immediate Cause (Final	te cause on each line.	12041	THR	OMBO	2510		1	Onset and D	
	/Medical		disease or condition resulting in death)	a. Due to (or as a co	onsequence of):	7///	0 0-110				WEE	K
	Examiner		Consumering lies and distance									
	D =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a co	onsequence of):							
	ecute and trans	Examin	Cause (Disease or injury that initiated events resulting in death) Last	)						-		
3/60,	ate be executed hysician and the burial-transit	al E	resulting in death) Last Due to (or as a consequence of):									
189	ate hy:	dical		J								
	death certifica e attending ph d for use as ti	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of p		_			23d. Date	of delive	erv.	
X Q Q	death a atter d for (	Ciar	in the past 12 months?	1☐Live birth 2 ☐ 4☐Pregnant at time		⊒Ectopic pregnancy ⊒ Other <i>(specify)</i>			Mon			Year
j.	the y th	hys	9 Unknown	9☐ Unknown								
ς. Τ	requires that the de een signed by the a nould be detached f	by P	Part II. Other significant conditions con	ntributing to death but no	ot resulting in the a	nderlying cause giv	en in Part I.		icco use contri			
ğ	w require been si should b							1 🗆 Yes	2/□N0	3 Prob	ably 4 🗆 L	Jnknown
ecord		Completed						24a. Was an autopsy	P	rior to con	psy findings a mpletion of ca	available ause of
<u> </u>	The cate has page	Con						perform 1 ☐ Yes 2	9d? d	eath?	2 🗆 No	
Vital	Physician: The law this certificate has t ral director, page 2 s	Be	25. Was case referred to medical examiner?	Hospital:		Oth	1 4 6	eath (Check only one	)			
0	this ald	2	1 ☐ Yes 2 ☑ No  27. Manner of Death	1 L Inpatient	2 ER/Outpatie		4 Nursing	Home 5 Resider			1)	
	ding F h. After funer	tion	1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Ye	ear) Injury	Wor	yat k? Yes 2 ⊡No	28d. Describe nov	rinjury occurre	ia .		
Vision	Attending it death.	fica	3 Suicide 6 Could not be	28e. Place of Injury	- At home, farm, st			28f. Location (Stre		or Rura	I Route Num	ber,
$\leq$	after after I Dire	Certification:	4 Homicide	building, etc. (S	Specify)	,		City or Town,	State)			
	e Hospital or Attend 24 hours after deatl Funeral Director: etely filled in by the		29a. Certifier 1 Certifying Phy	sician: To the best of m	ny knowledge, dear	th occurred at the tin	ne, date and place	ce, and due to the car	ise(s) and mar	ner as st	ated.	
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	ledical	one)	ner: On the basis of exa and manner stated	ammadon and/of if							7)
	To To	Σ	29b. Signature and title of certifier  29c. License number  29d. Date signed (Mont APRIL 12)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  D-D-ATEL, M-D-6(2) MONTROSE PO, ROCKVIVE MO 2085									
	7		1/1/2004	- /4-U	A.	100	5084	1	FRIL 1	4 4	2005	
	-		30. Name and address of person who co	2	h (Item 23a) (Type	Print)	ROTH	ULK MIN	208	(-		
	Sta	ite	31. Date filed (Month, Day, Year)	32. <b>#</b> egistrar's	Signature _	1 000	20	100	-00	2		
	Denist	0.00	APR 1 4 20	105	. It a	RACES						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 200. 0035M Mar /Medical 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death **Examiner** 4c. County of Death pita OrchESTEr ENEra 405 Cambridge

If Under 1 Year | If Under 24 Hrs.

Wonths Days Hours Min. orchest 5. Social Security Number 2/4-34-882 6. Sex 7. Age (Irl yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🗹 F Director Yrs. Mary lano Usual Residence of Decedent filed within 72 hours after death with the Maryland 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits or 28a-f show the Medical Examinar must be notified at 1 Yes 2 PNo Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Sland Funeral tems 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 "naturel", or 1 Yes 2 No Specify: Black by 3 Widowed 4 □ Divorced leted 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Compl other then Elementary/Secondary (0-12) College (1-4or 5+) trozen Line Worker rocesing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) and Mental is marked MeeKins Mary Meekins *tanse* 2 19b. Mailing Address (Street and Number or Raral Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) item 27 i Cambridge, MD. 21613 inder 400 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Lo selion - City or Town, State permit. Pages Department of Importent: if it any injury or o once. 1 Burial 2 □ Cremation 3 □ Removal from State 105 Church Creek, MD Meekins Neck Cemetery \* 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
HENRY FUNERAL 21. Signature of Funeral Service Licensee Home, P. A. 510 Washington 54. ambridge Approximate Interval Between Onset and Death 23a. Part1 (The the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Intracrania **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) The law requires that the deeth certificate be executed nding physician and use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant atten for u 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 4 Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown should 24b. Were autopsy findings available prior to completion of cause of death? s certificate has b lirector, page 2 s autopsy performed? 2 2 No 1 Yes 2No or Attending Physicien: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 1 Natural 2 Accident 5 Pending 1 Yes 2 No investigation nere! Director: A 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours after of To the Funerel Direct completely filled in by 4 Homicide To the Hospitel Sertifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one)

State Registrar

29b. Signature and title of certifier

30. Name and ad Evgene

31. Date filed (Month, Day,

cress of person who completed cause of death (Item 23a) (Type, Print)

2005 Register's Signature

29c. License number

29d. Date signed (Month, Day, Year)

		_	1 - For Amend Item Registrar	25tatepei	Maryland43) eps Cel	1189058 rtificate o	health a	ind Mental H	/giene	05	14470
			1. Decedent's Name (First, Middle, Las	")		<del></del>		2. Date of D			3. Time of Death
	Physici /Medic		Ethel	J.	Coates			Apri	Day 1 14,	Year 2005	8:18 A <sup>M</sup>
	Examin		4a. Facility Name (If not institution, give			4b. City, Town	n, or Location o			nty of Death	
			Union Hospita	1		Elkto	n		Ce	ecil	
	Funeral Director		5. Social Security Number 6. Se 166-12-9335	X □M 2☐F	7. Age (In yrs. last birthday) 84 Yrs.	If Under 1 Ye Months Da		8. Date of B (Month, E 2-9-1	irth 9ay, Year) 921	Cou	place (State or Foreign ntry) ord, PA
	pu N		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or Lo	anting					1011-11-01-11-1
	anyta shov				-						10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	he M	ecto	PA Chest	er	Oxfo						
	with t	Funeral Director	10e. Street and Number	m:11 n	a	10f. Zip Cod			10g. Citizen o		intry?
	s 23	erai	1044 Hickory			1936		in? (Casait: Van as h	USA	ace - Ameri	ann Indian
	Item Item	ů	11. Marital Status  1 ☐ Never Married 2 ☐ Married	Armed For	ces?	If Yes, specify C	cuban, Mexican	gin? (Specify Yes or N , Puerto Rican, etc.)	14. R	lack, White	
336	irs af		3X Widowed 4 □ Divorced	If Yes, Give	9	1 ☐ Yes 2 ☐	No Specify:		Spec	cify:	hite
21215-0036	72 hours after death with the Maryland neturel', or Hems 23s or 28s-1 show dical Examinar must be notified at	Completed by	15. Decedent's Ed		16a. Dece	dent's Usual Oc	cupation		16b. Kind of		
215	within 7: ene. then "n	pie	(Specify only highest grad	de completed) College (1-	(Give	kind of work do DO NOT use re	ne during most tired)	of working			,
21	filed within Hygiene. other then ent, the M	Ю	Eiementary/Secondary (0-12)		10.017	Homem	aker		Hon	ae	
	be filed within 72 hours after death with the Marylan ital Hygiene. ad other then "neturel", or litems 23s or 28e-1 show event. The Medical Examinar must be notified at	Be	17. Father's Name (First, Middle, Last)					r's Name (First, Middl		ame)	
/a	should be and Menta marked matic ev	10	Harry Joh	nson			Eth	el Mille	r		
Maryland	2 2 2 3 1 8 1 8 1 8 1 8 1 8 1 8 1 8 1 8 1 8 1		19a. Informant's Name/Relationship (7	ype, Print)	19b. Maili	ng Address (Str	eet and Numbe	r or Rural Route Num	ber, City or Tow	m, State, Zi	o Code)
	보고 를 다		Joseph H. Coat	es So		1 Towe				21788	3
ore	0 0		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐	Removal from S	20b. Place of Dispo cemetery, crei	sition (Name of matory or other	place) 4	1-18-2005	20c. Location	n - City or T	own, State
Ē	Pages ment of I ent: If its ury or o		`4 □ Donation 5 □ Other (Specify		Eastlan	d Fien	,		Notti	nghar	n, PA
Baltimore,	permit. Pages Department of Importent: If ii any injury or c		21. Signature of Funeral Service Licen	see	2:	2. Name and Ad	dress of Facility	Edward			
Ш_	905 29		CONTENSION COLLE	MS	F	uneral	Home,				Oxford, PA
П			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	lications that ca	used the death. Do not en						Approximate Interval Between
	Pnysician		Immediate Cause (Final disease or condition		ACUTE &	ESPIRATO	Pu Cu	15		- 1	Onset and Death
	/Medical		resulting in death)	Due to (c	or as a consequence of):						1 1100
	Examiner		Coguantially list conditions	h	ASPEATED	Termi	nal Asp	oiration		- 1	UNKNOWIN
1	D =	ner	Sequentially list conditions, cause. Enter Underlying	Due to (	or as a consequence of						
Ko	nd rans	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	c	VOMITING.						2-01-45
0,	sician and burial-transit		resulting in death) Last	Due to (d	or as a consequence of):						
8760,	cate be ex physician the burial	lica		d	METASTATIC	OVARIA	IN CAN	CER			UNICHONN
9	The taw requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE:						-		7.
Вох	ath ce ttend or us	lan/	23b. Was decedent pregnant in the past 12 months?	1 Live bi		Ectopic pregna				Date of deliv Month	ery Day Year
0.	the a	/sic	1 ☐ Yes 2 ⊠No 9 ☐ Unknown	4∐Pregna 9∐Unkno		Other (specify	")			violari	Day 76ai
P.	that the de led by the a detached	Phy	Part II. Other significant conditions of	atribution to do	ath but ant coulting in the		anna ia Dard I	22a Did	tehana was sa		the saves of death?
S,	res that signed to be det	by		_	_	ndenying cause	given in Part i.				the cause of death? bably 4 Unknown
oro	w require been sig should t	eted	MALIGNANT	ASCITE	\$				1165 21/40	30,110	Dadiy 4 Donknown
Records,	e taw has b	Completed						24a. Wa	opsv	prior to co	opsy findings available ompletion of cause of
		Col							formed? 2 🖾 No	death?	2□ No
Vital	Physicien: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:		_	0.1	of Death (Check only			
o	S S	2	1 Yes 2 No	Hospital: 1 🔯 Ir	patient 2 ER/Outpatie	IL SEL DOA		rsing Home 5 Res			(fy)
, LC	ling After Tune	lon	27. Manner of Death 1   Natural 5   Pending	(Month	of Injury 28b. Time of Injury Injury		njury at Work?		how injury occ	urrea	
Si	r Attending er death. rector: After by the fune	icat	2 Accident investigation 3 Suicide 6 Could not be	29a Plana	of Injury · At home, farm, st		l □ Yes 2 □ h		(Ctrant and Mu	mbar ar Dur	al Route Number,
Division	or A after Direction by	Certification:	4 ☐ Homicide determined	buildin	ig, etc. (Specify)	reet, lactory, oill	ce		own, State)	noer or nur	ai noute ivumber,
_	pitel	Ö	29a. Certifier 1 Certifying Ph	veician: To the	best of my knowledge, deat	h accurred at th	a time, data and	d place, and due to th	a causa(a) and		stated
	24 hos Fun etely	edical	(Check only 2 Medical Examone)	iner: On the ba	sis of examination and/or in	vestigation, in n	ny opinion, deat	h occurred at the time	, date and place	e, and due t	o the cause(s)
	To the Hospitel or Attent within 24 hours after death To the Funerel Director: completely filled in by the	Me	29b. Signature and title of certifier			29c. Lic	ense number		29d. Date sign	ned (Month,	Day, Year)
	⊢≯⊢ŏ		Wandan	•	m-b-		D0058	303	APRIL		
	10	1	30. Name and address of person who	completed cauca				312	. 112-11	17, 2	
	0		- A . C	A U. T. VAW	, UNION HOLP		6 BOW S	STREET EI	KTON, M	D 21	921
	Sta	atė	31. Date filed (Month, Day, Year)	32 Re				,			
	Regist		APR 1 5 20	05	egistrar's Signature						

State of Maryland / Department of Health and Mental Hygiene 0 0 5 For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) April Christopher Howard Davis **Physician** 22 2005 0400 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 13 B Fairview Avenue Taneytown Carroll County If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5 Social Security Number **Funeral** 1XM 2□F 54 Yrs. 9, 219-54-2814 Director Jan. 1951 Maryland Usual Residence of Decedent the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a State 28a-f show Yes 2 No Maryland Carroll County Directo Taneytown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 13 B Fairview Avenue 21787 United States Items 23a death Funeral permit. Pages 1 and 2 should be filed within 72 hours after deat Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural". or incorper in the properties of 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑Yes 2 ☐No 1970— 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: Specify: white Completed by 1976 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) automobile finance manager automobile finance 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be George C. Davis Frances Bryie ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Louise S. Davis / wife Fairview Avenue Taneytown, Maryland 21787 April 22 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 K Cremation 3 ☐ Removal from State Smithsburg Crematorium Smithsburg, Maryland <sup>1</sup> 4 □ Donation 5 □ Other (Specify) 2005 22. Name and Address of Facility Skiles Funeral Home 21. Signature of Funeral/Service Lifensee John M. Stiles 136 East Baltimore Street M00534 Taneytown, MD 21787 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Lun disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter or denying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: . If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy atter for u in the past 12 months?
1 Yes 2 No Year Month Day 4☐ Pregnant at time of death 5 Other (specify) þ 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Be Completed by ate has been signe page 2 should be KHOWH 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform certificate 1 ☐ Yes 2X No tha Hospital or Attanding Physician: director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification; After 1 Natural 5 Pending 2 🗌 No death. investigation 2 Accident **Director:** 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specily) 28f. Location (Street and Number or Rural Route Number, City or Town, State) þ 4 ☐ Homicide after within 24 hours a To the Funaral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier en . D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Center Westminster and 21157 0.1+2 5.55 Howard M.D. 31. Date filed (Month, Day Year) gistrar's Signature State 8 Registrar

			For State Registrar	State of Ma	ryland / Dep <i>Ce</i>	artment of F rtificate of			giene Reg. No. 🤈 🖺 🍸	) = 1   1   2   6
	Physici /Medic		Decedent's Name (First, Middle, La. Irving	st)	Dros	s		2. Date of Dea	11, 200	3. Time of Death 2 ear 12:32P M
	Examin		4a. Facility Name (If not institution, give Suburban Hospital	e street and number)		4b. City, Town, of Betheso	r Location of Dea	th	4c. County of	ntgomery
	Funeral Director		5. Social Security Number 6. S 050-30-0509 1	ex 7. Age	(In yrs. last birthday) 67 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min			Birthplace (State or Foreign Country) New York
	land		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or L	ocation				10d. Inside City Limits
	e Mary	ctor	Maryland Prince	George's	Laurel					1 ☐ Yes 2 🕱 No
	th with th	al Director	10e. Street and Number 11906 Lanner Plac	e		10f. Zip Code	20708		10g. Citizen of Wha United	
36	be filed within 72 hours after death with the Maryland that Hygiene. ad other than "natural", or Items 23a or 28a-f show event, I'ra Medical Exertirar must be redified at	by Funeral	11. Marital Status  1 □ Never Married 2 ☑ Married  3 □ Widowed 4 □ Divorced	12. Was Decedent Ev Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates: 10		Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 ☑ No	lispanic Origin? (S an, Mexican, Puer Specify:	Specify Yes or No- rto Rican, etc.)	14. Race - Black, Specify:	American Indian, White, etc. White
2-00	72 hour natural	eted b	15. Decedent's Ed (Specify only highest gra	lucation	16a. Dece	dent's Usual Occup	during most of wo	orkina	16b. Kind of Busin	
2121	- 29	Completed	Elementary/Secondary (0-12) 12	College (1-4or 5+	life.	DO NOT use retire	d)		Law	
Maryland 21215-0036	2 should be filed withir and Mental Hygiene. Is markad other than aumatic event, Ira M.	To Be C	17. Father's Name (First, Middle, Last) Samuel		Dros	SS	18. Mother's Na Lillian	me (First, Middle,		lberg
	nd 2 shoulth and N		19a. Informant's Name/Relationship ( Lillian Dross -wi						r, City or Town, Sta	
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 Is marked any Injury or other traumatic or ance.		20a. Method ol Disposition  1  Cremation 3  Cremation 3  Other (Specification 5  Other (Specification)		20b. Place of Dispe	osition (Name of	ce)	Date	20c. Location - Cit	ty or Town, State
Baltir	permit. P Departme Importan any Injur		21. Signature of Funeral Service Licer				1			PA Maryland 20705
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused to	he death. Do not en	ter the mode of dyir	ng, such as cardia	c or respiratory arr	est,	Approximate Interval Between
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a	consequence of):	infarctio	n			Onset and Death
ı	Examiner		Sequentially list conditions,	Congestiv	ve Heart I	Tailure				
	outed id ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a	consequence of):					
68760,	icate be executed physician and s the burial-transit		resulting in death) Last	Due to (or as a	consequence of):					
_	ertificat ding phy se as the	/Medical	IF FEMALE:	23c. If yes, outcome of	1000000					
P.O. Box	The law requires that the death certificate be executed as been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physiclan/M	23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown	1☐Live birth 2 4☐Pregnant at ti 9☐Unknown	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date o Month	
ds, P	uires that the de signed by the a ld be detached f	by	Part II. Other significant conditions of	ontributing to death but	not resulting in the u	nderlying cause giv	en in Part I.		_	ite to the cause of death?  Probably 4 Unknown
ecol	e law require has been sig ge 2 should t	Completed						24a. Was a		re autopsy findings available r to completion of cause of
a R			25. Was case referred to medical				26 Diago of Do	perfor 1 ☐ Yes ath (Check only or	<b>3√</b> No 1 □	th? Yes 2□ No
<u> </u>	hyaiclan: this certifice al director, l	To Be	examiner? 1 U Yes 2 Wo	Hospital:	t 2 ER/Outpatie	nt 3 DOA Oth	Ar.		ence 6 Other (	(Specify)
ouo	ding f		27. Manner of Death  12 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day		Wor	y at k? Yes 2 □ No	28d. Describe h	ow injury occurred	
Division of Vital Records,	I or Attendated after death	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injur building, etc.	y - At home, farm, st (Specify)	reet, factory, office		28f. Location (S City or Town		or Rural Route Number,
	To the Hospital or Al within 24 hours after of To the Funeral Direc completely filled in by	edical C	29a. Certifier 1 Certifying Ph (Check only one) 2 Medicaf Exam	ysician: To the best of niner: On the basis of e and manner state	examination and/or in	h occurred at the tirvestigation, in my o	ne, date and place pinion, death occi	e, and due to the curred at the time, d	ause(s) and manne ate and place, and	er as stated. I due to the cause(s)
	To the To the comp	Me	29b. Signature and title of certifier		- ^	<sup>29c.</sup> Licens 5541	0 0	2	9d. Date signed (A April 12,	Month, Day, Year) 2005
	24		30. Name and address of person who	completed cause of dea	ath (Item 23a) (Type,	Print)				
		10	Yevgeniy Gincherr  31. Date filed (Month, Day, Year)		de Cianatura		Rd. Bet	hesda, Ma	aryland 2	20814
	Sta Registr	_	RDD 1 2 20	320Registrar	H Des	we				

		State of Maryland / Depa state of Maryland / Depa not state of Maryland /	tificate of Death $^{-04/}$	15/2005	CUUSON	3. Time of Death
Physici /Medio		Page E. Dintaman	)	March 8,	2005	12:45 p.™
Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
		Vindabona Nursing Home  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Braddock Heights  If Under 1 Year   If Under 24 Hrs.	C Data of Birth	Frederi	
Funeral Director		5. Social Security Number  200–26–2355  Usual Residence of Decedent  6. Sex 1	Months Days Hours Min.	8. Date of Birth (Month, Day, 1)  July 28	, 1930 Ma	nplace (State or Foreign untry) <b>ryland</b>
aryland show	_	10a. State 10b. County 10c. City, Town or Loc  Maryland Frederick Braddock	cation  K Heights			10d. Inside City Limits 1 ☐ Yes 2 ☐ ₩6
the Ma	Director	10a. Street and Number	10f. Zip Code	10	g. Citizen of What Cor	
with	۵	6012 Jefferson Boulevard	21714		U.S.A.	untey:
2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "naturel; or Items 23a or 28a-f show eumatic event, the Medical Examble Intrast Let rudified at	/ Funeral	11. Marital Status  1 Never Married 2 Married  12. Was Decedent Ever in U.S. Armed Forces?  1 Yes 2 No	Nas Decedent of Hispanic Origin? (Spef Yes, specify Cuban, Mexican, Puerto F     □ Yes 2 No Specify:		14. Race - Amer Black, White	a, etc.
naturei',	Completed by	3 ☑ Widowed 4 ☐ Divorced Year or Dates:  15. Decedent's Education 16a. Decedent's Education (Give.	dent's Usual Occupation kind of work done during most of workin DO NOT use retired)	ng 1	6b. Kind of Business/I	white ndustry
d 2 should be filed within 72 hours af this and Mental Hygiens 27 1s marked other than "naturel; or treumatic event, the Medical Evani	omo	Elementary/Secondary (0-12) College (1-4or 5+)  12 Homema	,	B. Grand	Own home	
~ - 0 9	Be	17. Father's Name (First, Middle, Last)	18. Mother's Name		aiden Sumame)	
hould be d Mental narked o natic eve	2	Snively E. Glesner  19a. Informant's Name/Relationship (Type, Print)  19b. Mailin	Cora S		City or Tourn State 7	in Code)
nd 2 s aith an 27 Is r treu	1	1 1 2 1	Blakely Court, Fred		,	<b>21702</b>
it. Pages 1 ar intment of Hea intent: If Item: injury or other		20a. Method of Disposition 1 12/Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposementary, crem	sition (Name of Dinatory or other place)	Pate 2	Oc. Location - City or	Town, State
Pages Iment of tent: If Its jury or o		`4 □Denation 5 □Other (Specify) Lovettsvil				, Virginia
permit. Pages 1 and 2 should be Department of Heath and Menta Importent: If item 27 is marked any Injury or other treumatic evonce.			Name and Address of Facility Sta 621 Opossumtown Pi			
Physician / Medical Examiner  be provided as the private and private and private as the private	dicai Examiner	shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  C. Due to (or as a consequence of):  Due to (or as a consequence of):	MEART FAILU	RE.		Interval Between Onset and Death
The law requires that the death certifica to has been signed by the attending proage 2 should be detached for use as the	Completed by Physician/Medical		□Ectopic pregnancy □ Other (specify)		23d. Date of deli Month	very Day Year
quires that the d in signed by the uld be detached	ed by Ph	Part II. Other significant conditions contributing to death but not resulting in the un  CEREBROVISCULIVE ACCUR		1	acco use contribute to	
	e Complet	DEP NESS(ON).  25. Was case referred to medical	20 No. (O.)	24a. Was an autopsy perform	ed? prior to death? No 1 □ Yes	topsy findings available completion of cause of 2 No
or Attending Physicien: after death. Director: After this certification by the funeral director,	To B	examiner?  1 Yes 2 No  Hospital: 1 Inpatient 2 ER/Outpatien  27. Manger of Death Natural 5 Pending investigation  2 Accident  Note of Pending investigation			nce 6 Other (Spec	cify)
itel or Atterns after de rei Directo	Certification;	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, str building, etc. (Specify)		City or Town,		
To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	edical	29a. Certifier  (Check only one)  1 Certifying Physicien: To the best of my knowledge, death of the basis of examination and/or interpretable of certifier.  2 Medical Examiner: On the basis of examination and/or interpretable of certifier.	vestigation, in my opinion, death occurre	ed at the time, da	te and place, and due	to the cause(s)
To the within To the comple	×	29b. Signature and the of certifier MD	29c. License number 016675		APRIL II,	
		30. Name and address of person who inveled cause of death (Item 23a) (Tree.	PUNSWICK, H	2	4716	
St Regist	ate rar	31. Date filed (Month App R ear) 5 2005 32. Bustrar's Signature	Great 1			

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Yeer **Physician** Robert J. Douchis April 13 2005 9:36 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Cecil Union Hospital Elkton If Under 24 Hrs. 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) August 17,1941 Birthplace (State or Foreign Country) 5. Social Security Number Year **Funeral** 1**X** M 2□ F Days 63Yrs. Director 012-32-6346 Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits in than "natural", or items 23e or 28e-f show the Medical Examiner must be notified at 1 Yes 2 No Be Completed by Funeral Director MD Cecil <u>Port Deposit</u> 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 128 Chads Way 21904 USA filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specity: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Communication Engineer Federal Gov't Pages 1 and 2 should be filed w rement of Health and Mental Hygie rtent: if item 27 is marked other ti jury or other treumetic event, IL. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Ignatius Douchis Lillian Boris 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Terri VanDerzee/daughter 128 Chads Way, Port Deposit, MD 21904 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 04-16-2005 1 Burial 2 Cremation 3 Removal from State Department c importent: if any injury or \* 4 ☐ Donation 5 ☐ Other (Specify) R.T. Foard Funeral Home, P.A. Rising Sun, Maryland 22. Name and Address of Facility R.T. Foard Funeral Home, P.A. 21. Signature of Funeral Service Licen S. Queen Street, Rising Sun, MD unand that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, e on each line. 23a. Part1. Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final vastate Ca Metastalic Priysician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner To the Hospitel or Attending Physicien: The law requires that the death certificate be executed physician and s the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Records, P.O. Box 68760. Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 1 ☐ Live birth 2 ☐ Fetal death 3 Ectopic pregnancy Month Dav Year 4☐ Pregnant at time of death 5 Other (specify) signed by the all 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 1 🗌 Yes 2 No 2 H Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3□ DOA this After this funeral of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of Certification: 28d. Describe how injury occurred 1 Natural 5 Pending death. investigation 1 Yes 2 No 2 Accident Director: 3 🖺 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funerel C 1 Gertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier the of Jeath (Item 23a) (Type, Print) 30. Name and address of person wh. Dr. Martha Hosford, 111 W. High St., Elkton, MD 21921 31. Date filed (Month, Day, Year) 32 Registrar's Signature Registrar 2005

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.-Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month\_ Daff James /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Sacred Heart Hospital Cumberland Allegany 5. Social Security Number If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Jul 6, 1925 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months 1 ☑ M 2 ☐ F 234-32-4019 79 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 27 is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Examinat must be notified at MD Allegany Cresaptown Director 1 ☐ Yes 2 ☐ No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 14700 Wood Street 21502 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1□ Yes 2 No Specify: Specify: white þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Maintenance Holiday Inn 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Parley Daff Bessie Mae Cartwright Daff ٥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Veronica Daff wife 14700 Wood Street Department of Health a Important: If itam 27 Is any injury or other trangates. Cresaptown MD 21502 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Scarpelli Funeral Home, PA 4/27/2005 Cresaptown MD \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee. 22. Name and Address of Facility
Scarpelli Funeral Home, P.A. 108 Virginia Avenue; Cumberland, MD 21502 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician Inco. disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed the burial-transit attending physician and that initiated events resulting in death) Last Due to (or as a consequence of): Records, P.O. Box 68760, Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy ō Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1860 autopsy performed 1 Yes 2 X No 2 No Division of Vital To the Hospital or Attanding Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Impatient 2 2 ER/Outpatient 3 DOA the funeral 27. Magner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After Certification: Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 5 ☐ Accident after death Diractor: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral L 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 6911/190

State Registrar 517 Oldtown Road Cumberland MD 21502

30. Name and address of person who complet cause of death (Item 23a) (Type, Print)

N Ranjithan M.D.

ADHCLARENCE EVANS 05 - 2856

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death APRIL **Physician** 2005 0830 A M Edward Evans Clarence /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** ALLEGANY COUNTY NURSING HOME CUMBERLAND ALLEGANY If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. Dec 4, 1923 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral X**□ M 2□ F Director 217-18-4716 Usual Residence of Decedent Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours efter death with the Maryla Department of Health and Mental Hydene. Important: If item 27 is marked other than "natural", or items 23e or 28a-f show any injury or other treumatic event, the Medical Examiner most be rediffed at once. Cumberland MD Allegany X□Yes 2□No Director 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? USA 21502 477 Lena Street Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes Ž☐ No X Yes, Give Year or Dates: WWII Specify Specify white 3 ☐ Widowed ★ ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Local #616 .aborer 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Rosa Blanche O'Brien Evans Felix Edward Evans ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Ridgeley WV 26753 19a. Informant's Name/Relationship (Type, Print) Route 1 Box 424 stepson Jesse Jones 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4/28/2005 MD Hillcrest Memorial Park Cumberland 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Scarpelli Funeral Home, PA 21. Signature of Funeral Service License 108 Virginia Avenue: Cumberland, MD 21502 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final atherosclewtic cardiovascular Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner burial-transit that initiated events resulting in death) Last The law requires that the death certificate be execu Due to (or as a consequence of): Box 68760, by Physician/Medical the as IF FEMALE use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ō Month Day Year in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No detached Division of Vital Records, P.O. the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ✓ Yes 2 ☐ No 24a. Was an page 2 s has autopsy performed? 1 Yes 2 No or Attending Physicien: 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Yes 2 No Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 Tyes 2 No death. 2 Accident after death Director: 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide in 24 hours.
the Funerel Directors of the filled in the Hospitel 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 XMedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and 2 OCME APRIL 25, 2005 ted cause of death (Item 23a) (Type, Print) 111 Penn Street Baltimore, Maryland 21201 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

			1 - For State Registrar	State of	Marylar		artmer <i>rtifica</i> (				ental Hy	giene Reg. No. 🤈 🏻	105	1 1 1 009 000
	Physici	an	1. Decedent's Name (First, Middle,								2. Date of Dea	_	Year	3. Time of Death
	/Media	al	Ann M.	Free	h = 1		41. 03	T.	1	4 D 15	Apri1	9 2	2005	10:50 PM
	Examin	er	4a. Facility Name (If not institution, 6001 Muncaster I			House	4b. City		Location o				ly of Death Ontgo!	
	Funeral			S. Sex 7		last birthday)		r 1 Year	If Under	24 Hrs.	8. Date of Birt	n .		place (State or Foreign
	Director		157-20-3830	1 □ M 2 <b>X</b> F	76	5 Yrs.	Months	Days	Hours	Min.	(Month, Da) Nov. 5			Jersey
	pue *		Usual Residence of Decedent  10a. State 10b. County		10c. Ci	ty, Town or Lo	ncation							10d. Inside City Limits
	Maryla f sho	ō		ontgomery		Derv								1 ☐ Yes 2 🛣 No
	r 28a-	Director	10e. Street and Number				10f. Zip	Code				10g. Citizen of	What Cou	ntry?
	th with	al D	18801 Muncaste	er Road					208	55		Unit	ced S	tates
ဖွ	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: if Item 27 is marked other than "natural", or Items 23e or 28e-f show among injury other traumatic event, if a Medical Exercities I and be notified at once.	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☑ Marrie	12. Was Deced Armed Ford 1  Yes 2 If Yes, Give	ces? 2 <b>⊠</b> No		Was Dece If Yes, spe		spanic Ori n, Mexican Specify:		cify Yes or No- Rican, etc.)		ack, White,	
21215-0036	nours ural',		3 ☐ Widowed 4 ☐ Divorced	Year or Dat	tes:			-				Spec	iry: Wi	nite 
γ.	"nat	Completed	15. Decedent's (Specify only highest			(Give	dent's Usu kind of wo DO NOT u	rk done d	turina mos	t of worki	ng	16b. Kind of I	Business/Ir	ndustry
7	i withii iene. r than	omp	Elementary/Secondary (0-12) 12	College (1-	4or 5+)		nemak		/			Own	Home	
	e filed Il Hyg other	Be C	17. Father's Name (First, Middle, L.	ast)					18. Mothe	er's Name	(First, Middle,			
/lai	Menta Menta arked atic e	To E	James Boy:	le					An	na	Finn			
, Maryland	and 2 sho alth and 27 Is mark ar traum		19a. Informant's Name/Relationshi Bernard A. Fre		and		_				Route Number	-	_	o Code) 0855
Baltimore,	Pages 1 gent of He nt: If Item		20a. Method of Disposition  1 ★ Burial 2 □ Cremation 3  4 □ Donation 5 □ Other (Specific Specific	tate	Place of Disponentery, created the of I	matory or o	other place	1		3/05	20c. Location		own, State	
aĦ	mit. F partm portai y Inju		21. Signature of Funeral Service Li		1	-	2. Name a	nd Addres	s of Facilit	v			L OPI	ing, na.
<b>m</b>	P P P P P		muriel 1	1. Barl	un		P.	0. I	а. ва Вох <u>5</u>	038,	Funera Layton	т ноте sville,	Md.	20882
	Physician		23a. Part1. Enter the disease, or c shock, or heart failure. List o Immediate Cause (Final disease or condition	nly one cause on ea	ch line.	th. Do not en		de of dying	g, such as	cardiac o	r respiratory ar	rest,		Approximate Interval Between Onset and Death Years
	/Medical Examiner		resulting in death)	Due to (d	or as a consec	quence of):						-		
	, .	ner	Sequentially list conditions, any, leading to mind all cause. Enter Underlying Cause (Disease or injury	b. Due to (b	ras a consec	(Handa of)								
_	death certificate ba executed e attending physician and id for use as the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (c	or as a consec	uence of):								
8760,	te ba e ysician e burik	calE		d									T	
9	rtificat ng phy r as th	Medi	IF FEMALE:											
Вох	eath certific attending p	Physician/Medical	23b. Was decedent pregnant in the past 12 months?		th 2 Feta	al death 3	Ectopic p						ate of deliv	ery Day Year
o.	the y th	yslc	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□Unknov	int at time of o	jeam 5	Other (s	оеспу)						•
٥,	es that igned by be deta	by Ph	Part II. Other significant condition		ath but not res	sulting in the u	ınderlying	ause give	n in Part I.		23e. Did to	bacco use cor	ntribute to t	he cause of death?
Vital Records,	taw requires as been sign 2 should be		CHRONIC RENAL	FAILURE							1 🗆 Y	es 2 No	3 Pro	pably 4 ∐Unknown
ecc	e taw r has be je 2 sh	Completed									24a. Was		Were auto	opsy findings available empletion of cause of
= =	Th ate pag	Con									1 Yes	med? 2 No	death?	2□ No
Vita	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:		_	-	Oth			Check onl o			
of	shys this al dii	. To	1 ☐ Yes 2 No 27. Manner of Death	1 □ In	Commence of the last of the la	28b. Time of	-	-	4 🗆 140		ne 5 Resid			Mospice
on	oding Ph th. : After th s funeral	atlor	1 Natural 5 Pending 2 Accident investiga	(Month	, Day Year)	Injury	М	28c. Injury Work 1 🔲 `	(? Yes 2 🔲 I					
Division	l or Attending Fatter death. Director: After in by the funer	Certification:	3 Suicide 6 Could no 4 Homicide determin	led 286. Place	of Injury - At h g, etc. (Speci	nome, farm, st	reet, factor	y, office		2	28f. Location (S City or Tox		ber or Run	al Route Number,
	To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by		29a. Certifier 1 Certifying	Physician: To the I	best of my kn	owledge, deat	th occurred	at the tim	ne. date an	d place, a	and due to the	ause(s) and π	nanner as s	stated
	the Hohin 24 h the Fur	edical	(Check only 2 Medical E	xaminer: On the ba	sis of examina	ation and/or in	rvestigation	, in my or	oinion, dea	th occurre	ed at the time,	date and place	, and due t	o the cause(s)
	To the To the COMP.	Ň	29b. Signature and title of certifier	00			29	c. License				29d. Date sign		
	_		P. C. P.	. Teb	re 1	YD		D (	09470			APRII	. 10,	2005
_	10		30. Name and address of person w	RE, M.D.	10	0901 C	ONNEC	ricu	r AVE	NUE,	KENSI	NGTON,	MD.	20895
į	Sta Registi		31. Date filed (Month, Day, Year)	2005 Re	gistrar's Sign	ature Aps	all s							

			St 1 - State Amend Item 23a p						lygiene Reg. No. 2	75 11.1.70
			Decedent's Name (First, Middle, Last)					2. Date of	Death	3. Time of Death
	Physici /Medic		David C. Ford					APRI	L 12 <sup>Day</sup> 2005	14:55 M
	Examir		4a. Facility Name (If not institution, give street				vn, or Location		4c. County of	Death
			9000 BLK HOFFMAN - S	SEACHRIST R	D	WOODS			FREDER	ICK CO
	Funeral Director		5. Social Security Number 6. Sex 11XM Usual Residence of Decedent	7. Age (In yrs.		If Under 1 Y Months Da	ear If Under ays Hours	Min. 8. Date of (Month, April	Birth <i>Day, Year)</i> 17,1988	9. Birthplace (State or Foreign Country) Maryland
	and		10a. State 10b. County	10c. Ci	ty, Town or Lo	cation				10d. Inside City Limits
	Maryl f sho	ō	M1 1 7 1		Walker	sville				1 X Yes 2 □ No
	28a	Director	Maryland Frederic  10e. Street and Number	k	Walker	10f. Zip Cod			10g. Citizen of Wh	at Country?
	3a ol	O	307 Braeburn Drive			2	1793		United	Ctatas
	ms 2	Jere	11 Marital Status 12. V	as Decedent Ever in Umed Forces?	J.S. 13. \			rigin? (Specify Yes or n, Puerto Rican, etc.)	United S	American Indian,
9	after or fta	E.		☐ Yes 2 ☑ No Yes, Give	i	Yes 2				White etc. White
93	ral',	l by	3 ☐ Widowed 4 ☐ Divorced	ear or Dates:		105 20	No <i>Зр<del>о</del>спу</i>		Specify:	WILLEC
5-0	within 72 hours after death with the Maryland ene. than "natural", or Itams 23a or 28a-f show fs Mailgal Examithe matter	Completed by Funeral	15. Decedent's Education (Specify only highest grade con	n pleted)	16a. Deced (Give	lent's Usual Ockind of work de	ccupation one during mos etired)	st of working	16b. Kind of Busi	ness/Industry
121	within ne.	mpl		ollege (1-4or 5+)	Stud		etired)		Scho	201
2	filed within Hygiene. other than ant, it a M		11. 17. Father's Name (First, Middle, Last)		bead	ent	18 Moth	er's Name (First Mide	dle, Maiden Sumame)	
and	ad of	Be								
Z	should be tand Mental Is marked or umatic eve	2	David R. Ford  19a. Informant's Name/Relationship (Type, F	Print)	19b Mailin	n Address /St		erri Seymo	nber, City or Town, St	rate Zin Code)
Maryland 21215-0036	~ ~ ~ ~		Terri Seymour / Moth	,	1				* 918° 5	
	permit. Pages 1 and 3 Department of Health Important: If itam 27 any injury or othar tr. once.		20a. Method of Disposition	20b.	Place of Dispo	ountail sition (Name o	Green	Lane, Gai	20c. Location - Ci	ty or Town, State
no I	Pages nent of I ant: If its ury or of		1 ☐ Burial 2 ☐ Cremation 3 ☐ Remo `4 ☐ Donation 5 ☐ Other (Specify)	/al from State	cemetery, cren Tradari	natory or other	natory	4/18/2005	Enodouis	k, Maryland
Baltimore,	artme brtan injur		21. Signature of Funeral Service Licensee						Funeral Ho	
Ba	permit. Departri Imports any inju		1/mahan St	W. Mon					rederick,	
			23a. Part 1. Enter the disease, or complication shock or heart failure. List only one ca	ns that caused the dea						Approximate
	Dhusisian		immediate Cause (Final	use on each line. Si	noke in	halatio	on and	multiple i	njuries	Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	Due to (or as a conse	The off.	The	Ken			
	Examiner				450.105 01/1					
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conse	quence of):					
	cuted nd ransi	aml	Cause (Disease or injury that initiated events c							
o,	ate be executed hysician and the burial-transit	cal Examiner	resulting in death) Last	Due to (or as a consec	quence of):					
3760,	ate b hysic the bi		d							
k 68	ig p	by Physiclan/Med	IF FEMALE:							
Вох	that the death cer ed by the attendin detached for use	lan/	in the past 12 months?	yes, outcome of pregn □Live birth 2 □ Fet:	al death 3	Ectopic pregn			23d. Date of Month	·
o.	the a	ysic		☐ Pregnant at time of ∈ ☐ Unknown	death 5∟	Other (specify	y)		-	,
<u>α</u>	that til ed by detac	Ph	Part II. Other significant conditions contribu	ting to death but not re	sulting in the ur	nderlying cause	e given in Part	23e. Di	d tobacco use contribu	ute to the cause of death?
Records,	uires tha signed I d be det		•	•		,g	- <b>3</b>		∃Yes 2 ANo 3	☐ Probably 4 ☐ Unknown
Ö	w requir been si should	etec						24- 144	/\	
360	e law has	Completed							topsy prid	re autopsy findings available or to completion of cause of ath?
<u>=</u>	n: Th icate r, pag							1/2 Ye	2 No 1	Yes 2□ No
Vital	Physician: this certific ral director,	o Be	25. Was case referred to medical examiner?	al:	7.50.0		Other	e of Death (Check on		COPNE
of	Phys r this ral di	<del> </del>	1X Yes 2 No 1103pt 27. Manner of Death 28	1 inpatient 2	ER/Outpatien 28b. Time of	the same of the sa	4 🗆 14	ursing Home 5 Re	esidence XXOther be how injury occurred	
Division	Attanding ir death. ector: After by the fune	Certification:	1 ☐Natural 5 ☐ Pending 2 ☐ Accident investigation	a. ate of Injury Month, ay Year)	Injury		Injury at Work? 1 ☐ Yes 2 🕏		- X/auts	a cide of
İSİ	Attandii death. ctor: A y the fu	flca	3 Suicide 6 Could not be	e. Place of Injury - At h	nome, farm, str		/1	28f. Location	(Street and Number	or Rural Route Number,
Ö	after after of Direct of in by	erti	4 Homicide determined	building, etc. (Speci	STREET	5		9000 B	K. Hallone	1-Gas Lost RD
	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2		29a. Certifier 1 ☐ Certifying Physicie	n: To the best of my kn	owledge, death	occurred at th	ne time, date a	nd place, and due to the	ne cause(s) and mann	er as stated. 2/798
	na Ho na Fu na Fu	Medical	(Check only 2 XMedicel Examiner:	On the basis of examinated manner stated.	ation and/or inv	restigation, in r	my opinion, dea	ath occurred at the tim	e, date and place, and	d due to the cause(s)
	To the within To the Comp	Z	29b. Signature and title of gertifier			29c. Lic	cense number		29d. Date signed (i	Month, Day, Year)
			Y // Liter	(m		Date of the latest and the latest an	OCME		APRIL 13	, 2005
	di		30. Name and address of person who comple	ted cause of death (Ite	m 23a) (Type,					
	1,3		V. MEDUCK	EM)		111	Penn S	Street Ba	ltimore, M	aryland 21201
ge	Sta		31. Date filed (Month Day Year) 5 200	32. Posistrar's Sign		Coule				
	Regist	(ell		The state of the s	55° A					

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** April 11, 2005 4:28p Emory LeRoy Flickinger /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick Memorial Hospital Frederick Frederick If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Marke Days Hours Min. (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral**  Birthplace (State or Foreign Country) 1⊠M 2□ F Director 220-16-0347 80 2, 1924 Maryland Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits 28a-f show treumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 ☑ No Completed by Funeral Director Maryland Frederick Mount Airy 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō Items 23a 13645 Old Annapolis Road 21771 United States should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 1 X Yes 2 No If Yes, Give Year or Dates: WWII 1 ☐ Never Married 2X Married ō Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify White 3 Widowed 4 Divorced "naturel" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Dairy Farmer Farming 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Flickinger Ruth Boone 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 sl ment of Health an Doris J. Flickinger / Wife 13645 Old Annapolis Road Mt. Airy, Maryland 21771 other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State April 15 ö 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Importent: If any injury or once. `4 ☐ Donation 5 ☐ Other (Specify) Resthaven Mem. Gardens 2005 Frederick, Maryland 21. Signature of Pineral Service Licensee 22. Name and Address of Facility Stauffer Funeral Homes, P.A. 1621 Opossimtown Pike Frederick, Maryland 21702 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician ougestiv disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner oronary Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) P.O. I 1 ☐ Yes 2 ☐ No. 9 Unknown signed I 23e. Did tobacço use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Be Completed by 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 2 No 2∏ No 1 ☐ Yes 1 Tyes 25. Was case referred to medi examiner? Hospitel or Attending Physicien: funeral director, 26. Place of Death (Check only one) Other: 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) ihis 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. 2 Accident investigation within 24 hours after deat To the Funerel Director; 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) by 4 - Homicide contrying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only Medical Examine On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) 29b. Signature 29d. Date sigged (Month, Day, Year) MD 2005 × ise of death (Item 23a) (Type, Print) 30. Name and address of person who completed & gistrar's Signature Registrar

			For State Registrar	State of N	Maryland		artment of rtificate o				giene	0.01-	2 3 4
	Physici /Medic		1. Decedent's Name (First, Middle, Las Margaret	it)	L.	Fa	ir			2. Date of Dea Month April	Day 12,	2005	7:15 AM
	Examir		4a. Facility Name (If not institution, give Calvert Memor					e Fre	der			unty of Death Calve	
	Funeral Director		5. Social Security Number 212-20-1737  Usual Residence of Decedent	9X □M 2Y∏F	Age (In yrs. I	ast birthday) Yrs.	If Under 1 Ye Months Day	ar If Under ys Hours	Min.	8. Date of Birt Month, Day Sept.	2 , 192	9. Birth Cour Mar	place (State or Foreign htry) yland
	Maryland	tor	10a. State 10b. County Maryland Calv	ert	10c. City	, Town or Lo	nce Fr	ederi	.ck			1	1 Od. Inside City Limits
	th with the 23a or 28 ust be no	Funeral Director	10e. Street and Number 3820 Sixes R	oad			10f. Zip Code	20678			10g. Citizen	of What Cou	ntry?
9036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show important: If item 27 is marked other than "natural", or Items 23a or 28a-f show apprintly or other traumatic event, if a Modical Exertifiant and the Indiffication on the Item of Items	þ	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Midowed 4 □ Divorced	12. Was Decede Armed Force 1 ☐ Yes 2[ If Yes, Give Year or Date	s? XNo		Was Decedent of If Yes, specify C 1 ☐ Yes 2 🕅 N			ecify Yes or No- Rican, etc.)		Race - Americ Black, White, ecify: B1a	etc.
Maryland 21215-0036	od within 72 h giene. er than "natu	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12) 1 2		or 5+)	(Give lite.	dent's Usual Occ kind of work do DO NOT use ret Cashier	ne during mos ired)	st of worki	ing		of Business/In	•
yland	2 should be file and Mental Hy Is marked oth raumatic event	To Be (	17. Father's Name (First, Middle, Last) Samue1		Br	ooks		A 1	ice	(First, Middle,	(	Green	
	and 2 sho ealth and m 27 is m		19a. Informant's Name/Relationship (William Brooks			3820		Rd.	Pri	nce Fr	ederi	ick, M	ID 20678
Baltimore,	Pages 1 ment of H ant: If itel		20a. Method of Disposition  1   Burial 2 □ Cremation 3 □  4 □ Donation 5 □ Other (Specify		CE	ametery, crei 11an d	sition (Name of matory or other p Cemet	tery 4	/16		Hunti		n, MD
Ball	permit. Departn Importe any inju		21. Signature of Funeral Service Licen	Sewel	e-	1 <sup>22</sup> 1 <sup>2</sup> P r	Name and Ad 51 Dar ince F	dress of Facilities Be reder	y Ser each rick	well F Rd. , MD 2	unera 0678	al Hom	ie
	Physician		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	one cause on eact	sed the death line.		er the mode of o		cardiac o	or respiratory ar	rest,		Approximate Interval Between Onset and Death
	/Medical Examiner	l.			as a consequal Response as a consequal as a consequence as a conseq	- To To To	g ar	west					
	cate be executed obysicien and the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	s a consequal sa a consequal sa a consequal sa consequal sa consequal sa a consequence sa a consequal sa a consequal sa a consequal sa a consequal sa a consequal sa a consequal sa a consequal sa a consequal sa a consequal sa a consequal sa a consequal sa a consequal sa a consequal sa a consequal sa a consequal sa a consequal sa a cons	sis	()						
68760,	ficate be of physicients the buri	edlcal E	(	d	CVA	4							
O. Box	The law requires that the death certifics the has been signed by the attending ptogge 2 should be detached for use as I	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ Mo 9 ☐ Unknown	23c. If yes, outcor 1 □ Live birth 4 □ Pregnant 9 □ Unknowr	2 ☐ Fetal at time of de	death 3[	Ectopic pregna Other (specify)				23d	. Date of delive Month	ery Day Year
rds, P.	w requires that been signed b should be deta	by	Part II. Other significant conditions c	ontributing to death	n but not resu	ulting in the u	nderlying cause	given in Part	1.		obacco use		ne cause of death?
Records,	The law requirate has been page 2 should	Completed		· · · · · · · · · · · · · · · · · · ·							an 2 osy rmed? 2 10 100	prior to co death?	psy findings available mpletion of cause of
ita	ysician: Th is certificate director, pag	Bec	25. Was case referred to medical examiner?		,					(Check only o	ne)		
on of Vital	ding Phys h. After this funeral di	P.	1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending	Hospital: 1 Inpa		ER/Outpatier 28b. Time o Injury	f 28c. Ir	Other: 4 Nother: 4 Nother: Nother: 4 Nother: Nother: 4 Nother: Nother: Nother: 4 Nother: Nothe		me 5 Resid 28d. Describe h			y)
Division	or Atten ifter deat Director: in by the	Certification;	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of	Injury - At ho etc. (Specify	me, farm, sti	eet, factory, office			28f. Location (S City or Tow	Street and N vn, State)	umber or Rura	d Route Number,
	ne Hospital n 24 hours a ne Funeral t	Medical (	29a. Certifier Check only one) Certifying Ph	ysician: To the be niner: On the basis and manner	s of examinat	wiedge, deat tion and/or in	h occurred at the vestigation, in m	time, date ar y opinion, dea	nd place, ath occurr	and due to the ded at the time, d	cause(s) and date and pla	d manner as s ce, and due to	tated. the cause(s)
	To the within 2 To the Complet	M	29b. Signature and title of certifier  D. SUGL	MD				ense number D 50	29	1		gned (Month,	
	8		30. Name and address of person who		1.4	23a) (Type, ○ ≤ ↑	Print) RD	Pr	ina	fae	· de si	eh w	D 20678
	Sta Registi		31. Date filed (Month, Day, Year) APR 1 5 2005	200	strar's Signal		P						

		-	For State Registrar	State	of Maryland		rtment o			ental Hygi ™	ene 2 0	05	14481
			Decedent's Name (First, Mid	dle, Last)						2. Date of Death		Year	3. Time of Death
	Physicia /Medic		Phillip	Edgar	Gelvin	L				April 12	2, 2005		1:25 p M
j.	Examin		4a. Facility Name (If not institut	ion, give street and n	umber)		4b. City, Tow				4c. County		
			Calvert Memo			- A Birds do 3	Prince				C	alver	
	Funeral		5. Social Security Number	6. Sex 1 ☑ M 2 ☐ F	7. Age (In yrs. Ia	Yrs.	Months Da			Month, Day, Dec. 16	Year) 1946	9. Birthp	lace (State or Foreign try) liana
	Director		578-60-2245 Usual Residence of Decedent							Dec. 10	•1740	1110	itaria
	yland yland		10a. State 10b. Cour	ity	10c. City	, Town or Lo	cation					1	0d. Inside City Limits
	a-fs	ctor	MD Ca.	Lvert	N	orth E	each						1 □ Yes 2√ No
	ith th	Director	10e, Street and Number				10f. Zip Coo			10	g. Citizen of V		_
	s 23a		3836 6th	Street	anders Francis III	6 42.1	1	20714	Origin2 /Sp	positu Voc or No		.S.A.	ean Indian,
	items items	Funerai	11. Marital Status 1 □ Never Married 2 ☑ M	Armed F		5. 13. 1	f Yes, specify (	or Hispanic Cuban, Mexic	can, Puerto	ecify Yes or No- Rican, etc.)		k, White,	
35	or af	by F	3 Widowed 4 Divorce	ed lf Yes, G	: 2□No Sive Dates:1966–6	68	1□Yes 2🂢	No Speci	ify:		Specify	whi	ite
215-0036	J within 72 hours after death with the Maryland jiene. I than "neturel; or items 23a or 28a-f show Ite Medical Evaniner must be routified at	ted		ent's Education hest grade completed	0	16a. Deced	lent's Usual Or kind of work de	cupation	nost of work	dina 1	16b. Kind of Bu	siness/Ind	dustry
7	ithin 7	Completed	Elementary/Secondary (0-12		(1-4or 5+)	life.	OO NOT use re	tired)					
N	e filed will Hygier other th		12	(2. ( 2.24)		tr	ruck dr		thor's Nam	e (First, Middle, N	trans		ation
Maryland	D to D to	Be	17. Father's Name (First, Middle Phillip N.	Gelvin				18. MO	Flore	1	_	ump	
Ž	s 1 and 2 should be f Health and Menta item 27 is marked other treumatic so	은	Phillip N.  19a. Informant's Name/Relation			19b. Mailir	ng Address (St	reet and Nun		ral Route Number,			Code)
<u>8</u>	nd 2 sho Ith and 27 is m		Helen M. Gelv			P.O.	Box 40	2, Nor	th Be	each, MD	20714		
ē,			20a. Method of Disposition			lace of Dispo	sition (Name o	f			20c. Location -	City or To	own, State
altimore,	Pages nent of int: if it ury or o		1 ☐ Burial 2 💆 Cremation 1 ☐ Donation 5 ☐ Other		n State	-			y 4/1	3/2005 A	lexand	ria,	VA
<u>=</u>	permit. Page Department o Important; If any injury or once.	-	21 Statusture of Funeral Servi	ce Lice see		22	. Name and A	ddress of Fa	cility				
<u> </u>	2011		Dya		all					P.A.,		, MD	20736
L.			23a. Part 1. Enter the disease shock, or heart failure. I	or complications that ist only one cause of	t caused the death each line.	n. Do not ent	er the mode of	dying, such	as cardiac	or respiratory arre	est,		Approximate Interval Between Onset and Death
	Physician	ê P	Immediate Cause (Final disease or condition resulting in death)	_ a C	septica	mi	<b>*</b>					- 1	OUTE
	/Medical Examiner		, ,	Due t	o (or as a consequ	uence of:	nosi	2				11	4 GERRS
	200	Jer	Sequentially list conditions, if any, leading to inmediate	b. Due t	o (or as a consequ	uunou of):	inos i	3	0.51				0
	cuted od ransit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	رل . ک	ACRAI	De	Whit	us 1	Ulca	51		8	nonths
Ó,	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burral-transit	EX	resulting in death) Last	Due t	o (or as a consequ	uence of):							
8760,	icate be ex physician s the buria	dicai		d									
9 XO	eath certific attending pl	Physician/Med	IF FEMALE:	23c. If yes. o	outcome of pregna	ancv		AlA	_	11 1 30 30 31	23d Da	te of delive	BOY
8	atten for us	cian	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live	e birth 2 ☐ Fetal	I death 3	Ectopic pregr Other (specif				Mo		Day Year
o.	that the de ned by the a detached t	ysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	InU □e									
<u>α</u>	res that igned b	by Pi	Part II. Other significant cond		death but not resi	ulting in the u	nderlying caus	e given in Pa	art I.	23e. Did tob	acco use cont	ribute to t	he cause of death?
rds	w require been sig should b	ed t	ABOVE K	NGE DI	Mode	rrion	1 457	116	9	1 □ Ye	s 2□No	3 Prot	pably 4 Unknown
Records,	e law requ has been ye 2 shoul	piet							<b>V</b>	24a. Was a autops			opsy findings available impletion of cause of
æ	The ate has page	Completed								perform	ned?	death? 1 🗌 Yes	
Vital	Physicien: The this certificate har al director, page	Be (	25. Was case referred to med examiner?		1224				lace of Dea	th (Check only on	e)		
of/	S D	2	1 Yes 2 No		Inpatient 2  te of Injury	ER/Outpatie			Nursing H	ome 5 Reside			(y)
UC.	ding Ph h. After th funeral	ion	27. Manner of Death  1 Natural 5 Pe	(1.4)	onth, Day Year)	Injury	M 200.	Injury at Work? 1 Yes 2	2 □No	200. Describe no	ow injury occur	. 60	
Division	l or Attending after death. Director: Afte I in by the fune	fical	3 ☐ Suicide 6 ☐ Co	uid not be 28e. Pla	ace of Injury - At he				-	28f. Location (St	reet and Numb	er or Run	al Route Number,
Ω	i i i i	Certification:	4  Homicide	bu	ilding, etc. (Specif	<b>(y</b> )	_			City or Town	n, State)		
	To the Hospitel or Attent within 24 hours after death To the Funeral Director: completely filled in by the	edicai C		fying Physician: To cal Examiner: On the									
	o the ithin 2 o the omple	Med	29b. Signature and title of cer	A Mul	anner stated.			cense numb		-	9d. Date signe	d (Month,	Day, Year)
	- 5 - 0		1	Record	415		Ho	239	7220	smi	4/	12/0	5
F	5+1			son who completed ca			Print)				MD 20	CE7	
	, St	ate	Stephen P. Ca 31. Date tiled (Month, Day, Y APR 1 4 20	ear) 32	. Registrar's Signa	ature	_	ur. Si	iite .	2, Lusby,	, WD 20	05/_	
	Regist	rar	· · · 1 4 20	US Shrewa	) K.	toole							

			1 - Stata Amend Item 25	State of Marylan per Dr., G84	d / Depa 3 <b>,05/ፈ</b>	irtment of F	lealth and I <i>Death</i>		iene	5 11.100
	Dharatat		1. Decedent's Name (First, Middle, Last)					2. Date of Death	h Day Ye	3. Time of Death
	Physici /Medio		Jorge R. Garr	ido				April	12 2005	M
	Examin	er	4a. Facility Name (If not institution, give str	eet and number)		4b. City, Town, o	r Location of Deat	n	4c. County of D	eath
			Washington Adventi			Takoma				omery
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs.	last birthday) Yrs.	Months Days	If Under 24 Hrs. Hours Min.	(Month, Day,	rear)	Birthplace (State or Foreign Country)
	Director		578-78-4239 Usual Residence of Decedent	73	3 113.			Dec.14,1	.931	Chile
	/land		10a. State 10b. County	10c. Cit	y, Town or Lo	cation				10d. Inside City Limits
	Mary Fied	ţō	Maryland Montagna	***	Vone	! <b>!</b>				1 ☐ Yes 2 🙀 No
	r 28a	Director	Maryland Montgome  10e. Street and Number	L y	Kens	ington 10f. Zip Code	<del>.</del>	10	ng. Citizen of What	Country?
	be filed within 72 hours after death with the Maryland hat Hygiene. od other than "natural", or items 23e or 28e-f show event, the Medical Examiner must be notified at	0	3141-5 University	Rouloward U	00+	2089	15		TICA	
	ms 2	Funeral		. Was Decedent Ever in U.	S.   13. V	Vas Decedent of H	lispanic Origin? (S	pecify Yes or No-		merican Indian,
9	after or Ite		1 ☐ Never Married 2 🔀 Married	Armed Forces? 1 ☐ Yes 2 ★No		_	an, Mexican, Puerl	o Rican, etc.)		/hite, etc.
2	ral',	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		Yes 2□ No	Specify: Ch	ilean	Specify:	Vhite
Maryland 21215-0036	72 h	Completed	15. Decedent's Educa (Specify only highest grade of			ent's Usual Occup	ation during most of wor	rkina	16b. Kind of Busine	
21	within ene.	npi	Elementary/Secondary (0-12)	College (1-4or 5+)	life. L	OO NOT use retire	d)			
2	ygier ygier tt.	S		4	Laund	cy Techni			Healthc	are
ב	be fill d oth	Be	17. Father's Name (First, Middle, Last)				18. Mother's Nar	ne (First, Middle, N	faiden Sumame)	
<u>X</u>	ould Men Men arke	2	Ruperto Garrido				Maria M	atus Esp	inoza	
a	12 should be filled within h and Mental Hygiene. 7 Is marked other than " traumatic event, the Mas		19a. Informant's Name/Relationship (Type	e, Print)	19b. Mailin	g Address (Street	and Number or Ru	ral Route Number,	City or Town, Stat	e, <i>Zip Code)</i> 20895
	permit. Pages I and 2 should be Department of Health and Menta Important: If Item 27 Is marked any injury or other traumatic events.		Nelly Garrido	Wife	3141-	Univers	sity Boul			ington,MD
9	Que To To D		20a. Method of Disposition 1 ☐ Burial 2 ☒ Cremation 3 ☐ Rer	- Charles Charles C	emetery, cren	sition (Name of natory or other place	ce)	Date 2	20c. Location - City	or Town, State
Ξ	Pag tmen tant: jury		' 4 ☐ Donation 5 ☐ Other (Specify)	Met	ropoli Crem	atory	Apr.	16,2005 A	lexandri	a, Virginia
Baltimore,	eparl eparl npor ny in		21. Signature of Funeral Service Licensee			Name and Addre	ss of Facility	Funeral		15
_	<u>v</u> ∪ = ≅ d		Jans Elia	4	50	00 Univer	sity Blv	d.,W.,Si	lver Spri	ng,MD 20901
			23a. Part1 Enter the disease, or complication shock, or heart failure. List only one	tions that caused the death cause on each line.	n. Do not ente	er the mode of dyir	ng, such as cardiad	or respiratory arre	st,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	sensis						Onset and Death
	/Medical		resulting in death)	Due to (or as a consequ	uence of):					
	Examiner		Sequentially list conditions, b.	peritonitis						
	ַ בַּ	ine	cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequ	uence of):					
	cate be executed obysician and the burial-transit	Examiner	that initiated events c.	alcohotic lis	er dis	dSC				
ŏ,	e existan a	Ē	resulting in county Last	Due to (or as a consequ	uence of):					
8760,	ate b	dicai	d							
9	entific ling p e as	Med	IF FEMALE:							
Box	death certifi e attending p id for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?	<li>If yes, outcome of pregna 1 Live birth 2 Fetal</li>	death 3	Ectopic pregnancy	,		23d. Date of Month	delivery Day Year
0	t the dea by the a lached f	sic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 Pregnant at time of de 9 Unknown	eath 5□	Other (specify)			Wichiti	Day real
<u>о</u> .	that the	Ph		:L	dat - t - ab			an Didust		
	es be	by	Part II. Other significant conditions contr			derlying cause giv	en in Part I.			e to the cause of death?
5	w requir been si should	Completed	chronic obstructive f	numoriary aise	ase			1 ☐ Ye:	s 2 □ No 3	Probably 4 Unknown
of Vital Records,	e taw has b	pie	bleeding gastritis					24a. Was an autopsy		autopsy findings available to completion of cause of
Y	Th ate pag	Son	9 1					perform 1 Yes 2	ed? death	1?
<u> </u>	i <b>clan</b> : Th certificate ector, pag	Be (	25. Was case referred to medical examiner?				26. Place of Dea	th Check onl one		
×	S S	2	1 ☐ Yes 2 XNo		ER/Outpatient	3□ DOA Oth	er: 4 🗌 Nursing H	ome 5 Resider	nce 6 Other (S	(pecify)
	ng P fter t inera	Certification:	27. Manner of Death  1 XNatural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injur Wor	y at k?	28d. Describe how	w injury occurred	
<u>0</u>	eath. or: A	cati	2 Accident investigation			M 1 🗆	Yes 2 ☐ No			
UVISION	ter d Irect Irect	ŧ	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At he building, etc. (Specify	me, farm, stre	et, factory, office		28f. Location (Str. City or Town,	eet and Number or State)	Rural Route Number,
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.									
	Hosp 4 hou Fune ely fil	edicai	(Check only 2   Madical Examine	ian: To the best of my knore: On the basis of examination	wledge, death	occurred at the tir	ne, date and place	, and due to the car	use(s) and manner	as stated.
	the hin 2. the f	Medi	One)	and manner stated.			·			
	with Con	<	29b. Signature and title of certifier			29c. Licens		29	d. Date signed (Mo	onth, Day, Year)
	(		Flina Cummin	90, MD		D00 9	58919		April 13, :	2005
	>		30. Name and address of person who com				j.	_		
			Gina Cummings, MD	8807 Colesvi	He Road	l, Fifth Flo	or, Silver	Spring, M	D 20910	
	Sta		31. Date filed (Month, Day, Year) APR 1 4 2005	32 Registrar's Signa	ture dos	de				
	Registr	41	HLL TA COO	LUBBURD N						

			1 - For State Registrar	State of Maryla				•		
	0		Decedent's Name (First, Middle, Las.	1)				2. Date of Death	400	3. Time of Death
	Physicia /Medic		Marjory H. Gar	roway				April 8,	2005	2:51 A.M
	Examin		4a. Facility Name (If not institution, give			4b. City, Town, o	r Location of Deat		4c. County of Dea	
			Holy Cross Hospi	tal		Silver			Montgom	ery
	Funeral		Social Security Number     6. Se	7. Age (In yrs	s. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	(Month, Day, Yea	9. Bir	thplace (State or Foreign ountry)
	Director		213-38-2954 Usual Residence of Decedent	X	89 Yrs.			Oct. 21,	1915 Ca	lifornia
	land ow		10a. State 10b. County	10c. C	ity, Town or Lo	ocation				10d. Inside City Limits
	Mary Feat	ţo	Maryland Montgom	erv Si	lver S	nrina				1 Yes 2 No
	r 28a	Director	10e. Street and Number	ery 51	TAGE D	10f. Zip Code		10g.	Citizen of What Co	ountry?
	tied within 72 hours after death with the Maryland Hygiene. Ither than "natural; or Itams 23e or 28e-f show ant, the Maylical Examination Logified and	al D	3110 Gracefield R	oad		20904			U. S. A.	
	ams	Funeral	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S. 13.	Was Decedent of H If Yes, specify Cuba	lispanic Origin? (S	pecify Yes or No-	14. Race - Ame Black, Whi	
ç	or It	y Fu	1 Never Married 2 Married	1 ☐ Yes 2 XNo If Yes, Give	Ì	1 ☐ Yes 2 ☑ No	Specify:	, 0.0.,	Specify: W	
9500-61212	ural',	d by	3 XWidowed 4 □ Divorced	Year or Dates:						
γ	n 72	Completed	15. Decedent's Edi (Specify only highest grad	de completed)	16a. Dece (Give	dent's Usual Occup kind of work done DO NOT use retired	nation during most of wo. d)	rking 16b.	. Kind of Business	/Industry
7	withi ene. than	mc.	Elementary/Secondary (0-12)	College (1-4or 5+)		itor	-,		Journali	-m
7 0	tiled Hygi other ant, I		17. Father's Name (First, Middle, Last)		Eu	101	18. Mother's Nar	ne (First, Middle, Maid		SIII
<u>a</u>	ld be ental kad (	To Be	Abraham Isaac Ha	rris			Pearl F	elsenberg		
Maryland	permit. Pages 1 and 2 should be ilied within 72 hours after death with the Marylan Department of Health and Mental Hygiene.  Department of Health and Mental Hygiene.  Broad training the active that than "natural; or Itams 23a or 28a-f show any injury or other traumatic avant, the Medical Examinating must be indifficed at once.	_	19a. Informant's Name/Relationship (T		19b. Maili	ng Address (Street		ural Route Number, Cit	y or Town, State,	Zip Code)
Ĕ	alth a		Allen N. Garrowa	y - Son	871	Benjamin	Branch,	Davidsonvi	11e, Md.	21035
Baltimore,	itam itam		20a. Method of Disposition	20b.	Place of Dispo	osition (Name of matory or other place	ce)	Date 20c.	Location - City or	Town, State
Ĕ	Page nent car		1  Burial 2  Cremation 3  \ \ \ \ Donation 5  \ Other (Specify	nemovar nom State		id Mem. G	i i	11/05 Fa	lls Chur	ch, Virginia
<u>=</u>	porta porta y inju		21. Signature of Funeral Service Licens		2	2. Name and Addre	ss of Facility			
n —	8258		Donald (.)	Stattlemes	es 1	anzansky- 170 Booky	dolaberg	Memorial	onapers,	inc.
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	lications that caused the dea	ath. Do not en	ter the mode of dyir	ng, such as cardia	or respiratory arrest,	ic, mary.	Approximate Interval Between
	Pnysician		Immediate Cause (Final disease or condition	Myocardial						Onset and Death Days
	/Medical		resulting in death)	Due to (or as a conse						
	Examiner		Sequentially list conditions,	<sub>b.</sub> Pneumonia						Days
	si ad	Examiner	if any leading to immediate cause. Enter Underlying	Due to (or as a conse	quence of):					
	and and I-trans	каш	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a conse	aguanaa af\:					
3760,	ate be executed hysician and the burial-transit	icai E		Dus 10 (01 as a 001136	squerice or).					
68/	death certificate e attending phys od for use as the	dic		d						
	eath certific attending p	Physician/Med	IF FEMALE:	23c. If yes, outcome of preg	nancy	-			23d Date of de	livon
ROX	atter for u	ciar	in the past 12 months?	1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time of	tal death 3	□Ectopic pregnancy □ Other (specify)	/		23d. Date of de Month	Day Year
o.	at the de by the a tached	iysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown						
2	The law requires that the site has been signed by the bage 2 should be detache	by Pł	Part II. Other significant conditions co	ontributing to death but not re	esulting in the u	ınderlying cause giv	en in Part I.	23e. Did tobacc	o use contribute to	the cause of death?
Sp	w requires that been signed b should be deta		Hypertension					1 🗆 Yes	2 □ No 3 □ P	robably 4 XIUnknown
ecords,	s bee	Completed	Diabetes Mellit	us Type 2				24a. Was an	24b. Were a	utopsy findings available
Ĕ	The la	mo	Hyperlipsdemia	db lype z				autopsy performed 1 ☐ Yes 2 🔯	prior to	completion of cause of
Vital R	an: titica tor, p	Φ	25. Was case referred to medical				26. Place of Dea	1 ☐ Yes 2 ☑ ath (Check only one)	No 1 ☐ Yes	2 □ No
<u> </u>	To the Hospital or Attanding Physician: The law within 24 hours after death.  To the Funeral Diractor: After this certificate has I completely illed in by the tuneral director, page 2 sompletely illed in by the tuneral director, page 2.	To B	examiner? 1 ☐ Yes 2 💢 No	Hospital: 1 ☐ Inpatient 2[	☐ ER/Outpatie	nt 3 DOA Oth		lome 5 ☐ Residence	6 □Other (Spe	ecify)
Division of	ng Ph ter th		27. Manner of Death	28a. Date of Injury (Month, Day Year)		The state of the s		28d. Describe how in		
<u>0</u>	andir sath. or: Af	atic	1 XNatural 5 ☐ Pending 2 ☐ Accident investigation				Yes 2 □ No			
$\leq$	r Atta	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At building, etc. (Spec	home, farm, st	reet, factory, office		28f. Location (Street City or Town, St.	and Number or R ate)	ural Route Number,
	ital o irs af ral D		77							
	Hosp 4 hou Fune ely til	Medical	Check only 2   Medical Exem	ysicien: To the best of my ki liner: On the basis of examin	nowledge, deat nation and/or in	th occurred at the tir	ne, date and place	e, and due to the cause	(s) and manner as	s stated.
	the hin 2 tha mplet	Med	biley	and manner stated.						
,	Vil To		29b. Signature and title of certifier	1 / non		29c. Licens			Date signed (Mont	
1	2		160/10	reg/1	as : =		590	Ap	ril 8, 20	JU5
	•		Roy Fried, M.				ilver Sn	ring, Mary	land 200	904
	Sta	to	31. Date filed (Month, Day, Year)	37 Registrar's Sign		796	TIVEL DP	Lang, Hary.		, o . i
	Registr		APR 1 4 20	05	H DO	get 1				

		For	State of Mary	rland / Depa		Health a	and Men	tal Hygie	ne <sub>2</sub>	105	11.1.21
		Registrar			runcate of	Deam		Reg.	No.	- 00	1 4 4 0 4
Physici	an	Decedent's Name (First, Middle, L	ast)					Date of Death Month	Day	Year	3. Time of Death
/Medic		George Ha	inish					4	15	2m5	1:35 pM
Examin		4a. Facility Name (If not institution, g			4b. City, Town,	or Location	of Death		4c. Count	ty of Death	
Zamin	Ϋ'	University of Mar	lland Medical (	0 100	Ball	. 02.					
				yrs. last birthday)	Baltime If Under 1 Year	r If Under	24 Hrs.   8 F	Date of Birth		9 Birtho	lace (State or Foreign
Funeral			1 <b>X</b> M 2□F	50 Yrs.	Months Day		Min.	Month, Day, Ye	ar)		lace (State or Foreign try)
Director		215-64-0805	**	50			De	c 17	1954	Mary	land
p ,		Usual Residence of Decedent  10a. State 10b. County	10	c. City, Town or L	agation.					14	0d. Inside City Limits
ryla hov	_	Toa. State	1.0	ic. Oily, TOWITO L	ocation					'	
W S	얁	Maryland Washi	naton	Hagers	stown						1 ☐ Yes 2 No
1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Director	10e. Street and Number	ng con		10f. Zip Code			10g.	Citizen of	What Coun	try?
with with		20020 Gilbert	Hilla Deirro		2.	1742		TT-	oi tod	State	200
s 23	Funeral	20020 Gilbert	12. Was Decedent Ever	rin II S 13			rigin? (Specify			ice - Americ	
er de	Š	11. Marital Status	Armed Forces?	10.0.	Was Decedent of If Yes, specify Cu	ban, Mexica	n, Puerto Rica	in, etc.)		ack, White,	
aft o	Ϋ́F	1 Never Married 2 Married	If Yes, Give		1□Yes 2XIN	o Specify:	:		Spec	ity: Wh	ite
within 72 hours after death with the Maryland ene. than "naturel", or items 23e or 28e-f ehow he Madical Exerte at trival ke notified at	d by	3 Widowed 4 Divorced	Year or Dates:					,			
72 h netu	Completed	15. Decedent's (Specify only highest of		16a. Dece	edent's Usual Occ	upation	st of working	16	b. Kind of	Business/Inc	dustry
u e v	d	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	kind of work don DO NOT use reti	red)					
The series	E 0		1		Food Cle	erk			Gro	cery	Store
filed Hygir Sther ent,		17. Father's Name (First, Middle, La	st)		TOM CIT		er's Name (Fir	rst, Middle, Mai			
ed ala	Be	Garage Brankeld	n 17i ala Car				Todo Cr	oi olman			
should be filed within 72 hours after death with the Marylan and Mental Hygiene. Is marked other than "naturel", or Items 23s or 28a-f show matic event, the Medical Exerciser must be notified at	은	George Frankli						pielman			
2 sh and is m		19a. Informant's Name/Relationship	(Type, Print)	19b. Mail	ing Address (Stre	et and Numb	er or Rural Ro	oute Number, C	ity or Tow	n, State, Zip	Code)
1 and Heelth em 27 ther tr		Barbara K. Har	nish (wife)	200	20 Gilbe	ert Hi	lls Dri	ive Hage	ersto	wn Mai	ryland 217
permit. Pages 1 and 2 should I Department of Heelth and Men Importent: If Item 27 is marke any injury or other treumstic.		20a. Method of Disposition	12	20b. Place of Disp	osition (Name of		Date			- City or To	
Pages nent of i ont: If Its ury or o		1 Burial 2 Cremation 3	☐Removal from State	_	matory or other p		7 10	2005 1	T		Manueland
Part Int		`4 ☐Donation 5 ☐ Other (Spe	city)				_				Maryland
permit. Pag Department Importent: I any injury o		21. Signature of Funeral Service Lic	ensee	2	2. Name and Add	fress of Facili	ity Doug]	las A. 1	Fiery	Fune	ral Home
90 E 2 9		/ Yucha	A Trin	1, 1	1331 East	tern B	lvd. N.	. Hager	stown	. Mar	yland 2174
		23a. Part 1. Enter the disease, or co	mplications that caused the							1.5	Approximate
		shock, or heart failure. List or	ly one cause on each line.	100	à						Interval Between Onset and Death
Physician		Immediate Cause (Final disease or condition	-a. rulmon	ry Hu	orr hose.					- 1	3 days
/Medical		resulting in death)	Due to (or as a co		Q						12
Examiner											
	ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a co	onsequence of):							
ed sit	Examiner	cause. Enter Underlying									
be executed sician and burial-transit	can	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a co	oncoguence of):							
e ex ian i	ω.	, and a second s	Due to (or as a co	onsaquence or).							
ā × ā	cal		d								
that the death certifica ed by the attending ph detached for use as th	ed										
death certifica e attending ph id for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of p	pregnancy					23d. D	ate of delive	erv
atter for u	iar	in the past 12 months?	1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at tim		□Ectopic pregnar □ Other (specify)					<b>Nonth</b>	Day Year
e de pe	Sic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9☐ Unknown	ie or death 5	☐ Other (specify)				1		
by 1	, F	9 DONKHOWII							1		
es the igned be de	by F	Part II. Other significant condition	contributing to death but n	not resulting in the	underlying cause	given in Part	l.	23e. Did tobac	co use co	ntribute to th	ne cause of death?
urre s sig ld b								1 🗌 Yes	2 🗆 No	3 🗌 Prob	ably 4 Linknown
The law requires that the ste has been signed by the page 2 should be detached.	Completed							0.4 146	0.41	147	
law last	g				<del>-</del> ·			24a. Was an autopsy		prior to cor	psy findings available npletion of cause of
The law cate has page 2	0							performe 1 ☐ Yes 2-2		death?	2 No
	a)	25. Was case referred to medical				26 Plac	e of Death (C)	heck only one)			
Physician: this certificanal director,	8	examiner?	Hospital:	0 T F D 10							, and the same
this aldi	은	1 Yes 2 No	1 Impatient	2 ER/Outpatie	ent 3 DOA	4 L N		5 Residence			Y)
fter	o o	27. Manner of Death 1 ☐Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Yo	ear) 28b. Time (	V			. Describe how	injury occi	41160	
Attending r death. sctor: After by the fune	ati	2 Accident investiga			M 1	Yes 2	No				
Atte	1 1 1 1 1	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	ad 286. Place of injury	- At home, farm, s	treet, factory, offic	ж	281.			nber or Rura	l Route Number,
effe Dir	Certification:	4 Difficing	building, etc. (	Spacity)				City or Town, S	naio/		
Mospitel or Attendi 24 hours efter death Funerel Director: A etely filled in by the f		29a. Certifier 1 Certifying	Physician: To the best of n	ny knowledge, des	ith occurred at the	time data a	nd place, and	due to the earn	sp(s) and	manner as a	ated
Hos Fun Fun	edical	(Check only 2 Medical Ex	and the second second						and place	e, and due to	the cause(s)
To the Hospitel or Attending Phy within 24 hours effer death. To the Funerel Director: After thi completely filled in by the funeral	led	one)	and manner stated	u.							O. V-
To Too	Σ	29b. Signature and title of certifier	1		29c. Lice	ense number		29d	. Date sigr	ned (Month,	uay, Year)
		1/2.1 Par	Mu da		Acces	luse 1	. 6 . 1.	< 270	4/	15/-	
		mie Mi	ND ND	h (lto= 22-1 =	1444/70	543> 1 Del	r KOLITE 1-	2661	1//	1/05	
<i>(</i> )		30. Name and address of person w	to completed cause of deat	th (Item 23a) (Type St. Ballb	s, rnnt)	1 1	210 1		. 155		
4-10		Dared Berkowitz	- L J. Grans S	it Balt	more Mo	ryland	21201				
St	ate	31. Date filed (Month, Day, Year)	2005 32. Registrar's	Signature	1	,					
Regist	rar	AFK 18	4000 Allein	J. B. 16	marked						
					£						

		State of Maryland / Department of Health and M Certificate of Death		Reg. No.20	95	4485
Physicia /Medic		1. Decedent's Name (First, Middle, Last)  Leland Ray HOLLAND	2. Dete of De Month April		Year	Time of Death  2:50 a.m
Examin		4a Fecility Neme (If not institution, give street and number)  Julia Manor  4b. City, Town, or Low Hagersto		, ,	of Death ington	
Funeral Director	1		8. Date of Bir (Month, Da OCT • 2.	Year) 924	9. Birthplace Penns	(State or Foreigr y lvania
and	-	Usuel Residence of Decedent           10a. State         10b. County         10c. City, Town or Location			10d. I	nside City Limits
Manyl	ğ	Maryland Washington Hagerstown			1	☐ Yes 24000No
r 28a	Director	10e. Street end Number 10f. Zip Code		10g. Citizen of W	hat Country?	
th wit	a	1075 Mt. Aetna Road 21740		U	.S.A.	
be filed within 72 hours after death with the Maryland ital Hygiene. Id other then "naturel", or flems 23a or 28e-f ehow event, the Medical Examiner must be notified at	Completed by Funeral	11. Merital Status  1 □ Never Married 2 □ Married  3 □ Wildowed 4 □ Divorced  12. Wes Decedent Ever in U,S. Armed Forces?  13. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto If Yes, Give Year or Dates: 1945  14. Wes Decedent of Hispanic Origin? (Spe If Yes, Specify Cuban, Mexican, Puerto If Yes, Give Year or Dates: 1945	city Yes or No Rican, etc.)	14. Race Black Specify:	- American Ir	
c • @	npleted	15. Decedent's Education (Specify only highest grade completed)  Elementary(Secondary (0-12) College (1-4or 5+)  16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	ng	16b. Kind of Bu		
filed with Hygiene. Ather ther	S		/Fi 6 - 8 - 8 - 8 - 8 - 8 - 8 - 8 - 8 - 8	home i		ment
should be flied within nd Mental Hygiene. marked other than marked other than matic event, its Mental control of the Mental control	å	17. Father's Name (First, Middle, Last)  Charles Holland		, маюн sumam Mae Rus		
s should be and Mental e marked c	ဥ	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rure				(e)
d 2 d 2 d 2 d 2 d 2 d 2 d 2 d 2 d 2 d 2	1	Susan L. Glines - daughter 127 Catawba Place, Hag				1742
s 1 and 2 if Health item 27 if other tra	ŀ	20a. Method of Disposition 20b. Place of Disposition (Name of	Date	20c. Location -	City or Town,	State
ages ant of rt: If if y or o		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)  Cemetery, crematory or other place)  Cedar Lawn Memorial Park	pril 6.2005	Hagerst	own. Ma	arvland
permit. Pages Department of H important: If ite eny injury or of pnce.			Minnic	h Funera	1 Home	
	-	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac o shock, or heart failure. List only one cause on each line.	r respiratory a	rrest,	Apr	proximate
Physician /Medical Examiner		1	ilur		Ons	erval Between set and Death
ficate be executed physician and as the bunal-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as e consequence of):	١ ٢			
th certific tending p or use as	Physician/Me	d				
the al	yslc	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.	23b. Did	tobacco use con	tribute to the	
that the ed by detac	F.		1 🗆	Yes 2□No	3 Probabl	y 4⊠Unkno
The law requires that the death certif ate has been signed by the attending page 2 should be detached for use a	Completed by		24a. Was	en autopsy ormed?	availab	tutopsy finding: le prior to stion of cause h?
nysician: The law his certificate has I I director, page 2 s	E 00		10	Y09 2/21/10	1 ☐ Ye	s 2 No
slan: ertific ector,	Be	25. Was case referred to medical examiner?	(Check only	one)		
<b>₹</b> = 6	유	27. Menner of Death 1 Natural 5 Pending 28. Dete of Injury 28b. Time of Injury 28c. Injury at Work? 28c. Injury at Work?		idence 6 Other		
To the Hospital or Attending Phywithin 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral	Certification:	2 Accident		(Street and Numbe wn, State)	er or Rural Ro	ute Number,
n 24 hour n 24 hour e Funera	Medical	29a. Certifier (Check only one)  1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, a construction of my death occurred at the time, date and place, a construction one)				
Vithie To th comp	ž	29b. Signature and title of certifier  29c. License number		29d. Date signed	(Month, Dey	Yeer)
		January 10060396		04/11	5105	4
1-3			(0 W	21740	lager	stown
Sta Registr		31. Date tiled (Month (13) (Year) 8 2005 32. Registrer's Signature		1		

DHMH 16 Rev 6/95

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Year **Physician** AM Dorothy Jean HOSE 083 2005 tori /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Washington Washington County Hospital Hagerstown If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) March 17, 1931 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Months Min. 1 □ M 2 🖾 F 74 Yrs. Alabama 416-36-4540 Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r then "neturel", or Items 23s or 28s-f show the Medical Examiner must be nutitied at tXXYes 2 ☐ No West Virginia Berkeley Falling Waters Direct 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 110 Imperial Way 25419 U.S.A. death 1 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 □ Never Married 2 N Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White \$ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) her own home homemaker 0 - 110 permit. Pages 1 and 2 should be file Department of Health and Mental Hy, importent: if item 27 is marked other any injury or other traumatic and injury or other traumatic and the statement of t 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Harvey Faulk Eddie Lee Hayes ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Billy E. Hose - husband 110 Imperial Way, Falling Waters, West Virginia 25419 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State April 18, Rose Hill Cemetery \* 4 □ Donation 5 □ Other (Specify) 2005 Hagerstown, Maryland 21. Signature of Funeral Service Licensee Minnich Funeral Home 22. Name and Address of Facility 415 East Wilson Blvd., Hagerstown, Maryland 21740 210 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final months Physician Ulmonary Dr051 disease or condition resulting in death) /Medical Due to (or as a consequence of **Examiner** estive 0n9 Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury as a consequence of): Examine use as the burial-transit that initiated events and resulting in death) Last Due to (or as a consequence of): Box 68760. ed by the attending physician detached for use as the buria certificate be Physician/Medical IF FFMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy Month in the past 12 months? Day Year 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 1 Yes 2 No 9 Unknown 9 Unknown s been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? certificate 1 ☐ Yes 2 No Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 1 Yes 2 No 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) funeral 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After 1 Natural 5 Pending death. М 1 ☐ Yes 2 ☐ No investigation after death 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospitel within 24 hours a To the Funerel L 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 4-15-2005 Masi D21457 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AVE. HAGERSTOUR. MO21742 /ABOUL WATTERD MO-12821-OAKHIL 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

14487 State of Maryland / Department of Health and Mental Hygiene UUD

			1 - State Registrar		Cer	tificate of	Death	Re	eg. No.	/
	Dhypini		1. Decedent's Name (First, Middle, Last)					2. Date of Death	h Day Year	3. Time of Death
	Physicia /Medic	-	Grace Mary Hanna						16, 2005	12:45 P M
	Examin		4a. Facility Name (If not institution, give s	reet and number)		4b. City, Town, o	r Location of Death		4c. County of De	
			Kline Hospice Hous			Freder			Frederi	
	Funeral		5. Social Security Number 6. Sex	7. Age (/.	n yrs. last birthday) 76 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year) 9. B	irthplace (State or Foreign Country)
	Director		216-22-9343	X	76 Yrs.			August 1	16,1928 Ma	ryland
	land ow		10a. State 10b. County	10	Oc. City, Town or Lo	cation				10d. Inside City Limits
	Mary -f sh	tor	Maryland Frederic	ζ	Freder	ick				1 ☐ Yes 2 No
	7 28a	rec	10e. Street and Number			10f. Zip Code		10	0g. Citizen of What (	Country?
	h with	ai D	2511 Shelley Circle	9		21702			USA	
	filed within 72 hours after death with the Maryland Hygiene. ther than "naturel", or Items 23a or 28a-f show ent, the Medical Evanthwermant Leundillied at ent, the Medical Evanthwermant Leundillied at	Funeral Director	11. Marital Status	Was Decedent Eve Armed Forces?		Was Decedent of H	fispanic Origin? (Sp an, Mexican, Puerto	pecify Yes or No-	14. Race - An	
Q	or Ite		1 Never Married 2 Married	1 Tes 2 No	ì	1 □ Yes 2 🕱 No	Specify:	rwan, etc.)	Black, Wh	iite, etc.
	urel',	d by	3X Widowed 4 ☐ Divorced	Year or Dates:					Specify: Wh	ite
2	"nati	Completed	15. Decedent's Educ (Specify only highest grade	ation co <i>mpleted)</i>	(Give	dent's Usual Occup kind of work done	durina most of worl	king	16b. Kind of Busines	s/Industry
7	withir sne.	m	Elementary/Secondary (0-12)	College (1-4or 5+)		DO NOT use retired	2)		Гаа.	
N 5	Hygie ther ther	e Co	17. Father's Name (First, Middle, Last)		Teach	ers Aide	18. Mother's Nam	ne (First, Middle, M	Education	ו
<u>a</u>	d be antal	03	Harry Oliver Brits							
>	should be f and Mental P s marked of umatic eve	<sup>2</sup>	19a. Informant's Name/Relationship (Type	_	19b. Mailir	na Address (Street		orrow Ir	WIП ; City or Town, State,	Zin Code)
	d T		Carol Fritts - dau	ahter		ld Home			aryland 21	
w .	s 1 au f Hea ltem othe		20a. Method of Disposition		20b. Place of Dispo				20c. Location - City of	
Ē	Page ent o nt: If ry or		1 XBurial 2 ☐ Cremation 3 ☐ Re  4 ☐ Donation—5 ☐ Other (Specify)		Green Lawr			-2005 W	/illiamsno	rt,Maryland
Бантітог	permit. Pages 1 and Department of Heall Importent: If Item 2 eny injury or other Once.		21. Signature of Funeral Service License				ss of Facility		eral Home,	D. A.
ñ	Deparential Depare		I ( sun le	Jh	Δ	25 S Cor	ocochean	orne rund	era: Home,	P.A.
			23a. Part1. Enter the disease, or complice shock, or heart dilure. List only on	ations that caused the	e death. Do not ent	er the mode of dyir	ng, such as cardiac	or respiratory arre	est,	Approximate
	Physician		Immediate Cause (Final disease or condition	7	no Conc					Onset and Death
	/Medical		resulting in death)	Due to (or as a c	onsequence of):	Cr				U MUNITER
	Examiner		Sequentially list conditions							
	D #	Iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a c	onsequence of):					
	and trans	Examiner	that initiated events resulting in death) Last	Due to (or as a c	anagarana afti					
Ď,	certificate be executed uding physician and use as the burial-transit			Due to (or as a c	orisequence or).					
08/00	physi the	Medical	d d							
×	din Se	*	IF FEMALE:	3c. If yes, outcome of	pregnancy				224 5-4-44	-1
0	atter for u	cian	in the past 12 months?	1 Live birth 2 ( 4 Pregnant at tim	Fetal death 3	Ectopic pregnancy Other (specify)	1		23d. Date of d Month	Day Year
j.	nrequires that the de been signed by the should be detached	Physician	1 Yes 2 No 9 Unknown	9☐ Unknown		2 0 11 01 (0,000 11)/				
Σ.	requires that een signed b hould be deta	by PI	Part II. Other significant conditions con	tributing to death but r	not resulting in the u	nderlying cause giv	en in Part I.	23e. Did tob	pacco use contribute	to the cause of death?
	quires n sign							1 🖭 🗡 e	s 2 No 3 1	Probably 4 Unknown
Kecords,	law reas bee	ompieted						24a. Was ar	n 24b. Were	autopsy findings available
	0 5 0	mo						autops perform	ned? prior to death?	autopsy findings available completion of cause of
VII	sician: Th certificate rector, pag	e C	25. Was case referred to medical	-			26. Place of Dea	th (Check only one		2 2 140
	S	To B	examiner? 1 ☐ Yes 2 ☑ No	ospital: 1   Inpatient	2 ER/Outpatier	nt 3 DOA Oth			ence 6 Techner (Sp	ecity) Hospice
10 0	ter thi		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Y	ear) 28b. Time of	f 28c. Injur Wor	y at k?	28d. Describe ho	w injury occurred	for derek
<u>Ö</u>	r Attending Per death. rector: After by the funera	atic	2 Accident investigation				Yes 2 □ No			
Division	irect irect	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc. (	<ul> <li>At home, farm, str Specify)</li> </ul>	eet, factory, office		28f. Location (Sti City or Town	reet and Number or i n, State)	Rural Route Number,
_	spitel or ours afte erel Dir filled in									
		Medical	29a. Certifier 1 Certifying Phys (Check only 2 Medical Exemir	ician: To the best of n	amination and/or in	h occurred at the tir vestigation, in my c	me, date and place, ppinion, death occur	and due to the ca red at the time, da	ause(s) and manner a ate and place, and d	as stated. ue to the cause(s)
	vithin 24 h To the Fur completely	Med	29b. Signature and title of certifier	and manner stated	J.	29c. Licens	se number	20	9d. Date signed (Mo	nth. Dav. Year)
	E 2 E 8		Dail 1	m. 1.	1 11				7.1	
			30. Name and address of person who co	moleted cause of door	h (Item 23a) (Tupo		41667		9.18	.03
21	4-8		Michael McCa				(an	in la	heres his	m m o

State Registrar

		State of Maryland / Depa	rtment of Health and M	•	711113	14488
Physic /Medi		Decedent's Name (First, Middle, Last)     MARGARET NMN HOUPT		2. Date of Death Month APRIL 1	25, 2005	3. Time of Death 2130 M
Exami		4a. Facility Name (If not institution, give street and number) 310 S. MAIN STREET		INGTON		
Funeral Director		5. Social Security Number 6. Sex 1 → N. Age (In yrs. last birthday) 1 → N. 2 → R. Age (In yrs. last birthday) 82 Yrs.	If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth MAY 7,	9. Birth	place (State or Foreign IARYLAND
Maryland I-f ehow	tor	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Loc  MARYLAND WASHINGTON	ation BOONSEORO			10d. Inside City Limits 11√2 Yes 2 □ No
th with the 23a or 28a st be not	Funeral Directo	10e. Street and Number 310 S. MAIN STREET	10f. Zip Code 21713	10g.	Citizen of What Cou	intry?
ire, INIATY IANG ZIZIO-0050  s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is markad other than "natural", or Itama 23a or 28a-1 ehow other traumatic event, the Madical Examinar must be notified at		11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 Yes 2 No If Yes, Give Year or Dates:	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White Specify:		
d within 72 he giene.	Completed by	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0·12)  College (1-4or 5+)	ng 16b	. Kind of Business/li	ndustry HOME	
/IZING	To Be (	17. Father's Name (First, Middle, Last) ESBY EUGENE CRONISE		(First, Middle, Maid	len Sumame)	
y, Mar, and 2 sho salth and 1 n 27 is ma	6 8	GERALD E. HOUPT, SON 10 V	NADA Address (Street and Number or Rura NYE OAK DRIVE, FUN	KSTOWN, N		21734
	100000		ition (Name of atory or other place)  N MEM. PARK 4/20/		Location - City or T	own, State  N, MARYLAND
BAITIMO  permit. Pages Department of important: If i any injury or o		21. Sapadur & Frieral Servicence 22.	Name and Address of Facility BAST FUNERAL HOMI		D NATIONA DRO, MARYI	
Physician /Medical Examiner	Examiner	23a. Part1. Ende the disease, or complications that caused the death. Do not enter shock, or leart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events  Due to (or as a consequence of):	/	r respiratory arrest,		Approximate Interval Between Onset and Death
hat the death certificate be executed that the death certificate be executed ed by the attending physician and detached for use as the buriat-transit	Physician/Medical Ex	in the past 12 months?  1 Ves 2 PMo 4 Pregnant at time of death 5	Ectopic pregnancy Other (specify)		23d. Date of deliver Month	rery Day Year
S P B	Ď	9 Unknown  Part II. Other significant conditions contributing to death but not resulting in the unc	derlying cause given in Part I.		the cause of death?	
The law ate has b page 2 st	Completed			24a. Was an autopsy performed 1 Yes 22	prior to co	opsy findings available ompletion of cause of
n OT ng Phy Itter this rneral d	ertification: To Be	25. Was case referred to medical examiner?  1	28c. Injury at Work? M 1 ☐ Yes 2 ☐ No		njury occurred  and Number or Rui	
DIVISIO To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the to	Medical C	29a. Certifier (Check only one)  2 Medical Examiner: On the basis of examination and/or investigation and manner stated.	occurred at the time, date and place, a estigation, in my opinion, death occurred	ed at the time, date a	e(s) and manner as and place, and due	to the cause(s)
To Viit O	-	I the F. Godh	0005682	1	-	
JH-5	1010	30. Name and address of person who completed cause of death (Item 23a) (Type, P William F. Bodenheimer, M.D., 9 St.  31. Date filed (Month, Day, Year) 32. Registrar's Signature	Paul Street, Boon	sboro, MD	21713	
Regis	tate trar	31. Date filed (Month, Day, Year)  APR 18 2005  32. Registrar's Signature	eds.			

	•	For State of Maryland  1 - State Registrar	-	irtment of He tificate of D			giene Reg. No.	
_ •	ie .	Decedent's Name (First, Middle, Last)				2. Date of De	ath .	3. Time of Death:
Physicia /Medic		Robert Earl Harpster				Month April	Day Year 24. 2005	6:30p M
Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or I	Location of Death		4c. County of Dea	ith
		Frederick Memorial Hospital		Frederi			Frederi	ck
Funeral Director		210 10 0331	st birthday) 7 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bin (Month, Da Nov. 19	th 9. Bir	thplace (State or Foreign ountry) 'Yland
put *	-	Usual Residence of Decedent  10a. State 10b. County 10c. City,	Town or Loc	cation				10d. Inside City Limits
e Maryla Be-f sho	Director	Maryland Frederick County Em	mitsbu	urg		,		1 XYes 2 □ No
th with th	ai Dire	10e. Street and Number  8 Waycross Court		10f. Zip Code 2:	1727		10g. Citizen of What C United Stat	-
2 should be filed within 72 hours after death with the Maryland 2 should be filed within 72 hours after death with the Maryland 1s marked other than "nature!", or liems 23a or 28e-f show reumatic event, the Medical Examiner must be notified at	by Funeral	11. Marital Status  1 □ Never Married 2 ☒ Married  3 □ Widowed 4 □ Divorced  12. Was Decedent Ever in U.S Armed Forces?  1 ☒ Yes 2 □ No If Yes, Give Year or Dates: 1975	1	Vas Decedent of His I Yes, specify Cuban I ☐ Yes 2払 No	spanic Origin? (Spe , Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)	14. Race - Am Black, Whi	ite, etc.
n 72 hou nature	leted	15. Decedent's Education (Specify only highest grade completed)	16a. Deced (Give I	lent's Usual Occupation of work done do NOT use retired)	tion uring most of worki	ing	16b. Kind of Business	s/Industry
led withii ygjene. her than it, it a M	Completed	Elementary/Secondary (0·12) College (1-4or 5+)		cipal wor	ker		municipal	ity
y carry	To Be	17. Father's Name (First, Middle, Last) Larry Earl Harpster			Shirley		, Maiden Sumame) reen	
te, man ying ying ying ying ying ying ying yin		19a. Informant's Name/Relationship (Type, Print) Karen Marie Harpster / wife		g Address (Street ar aycross C			er, City or Town, State, rg, Marylar	•
permit. Pages 1 and 2 Department of Health a Importent: If item 27 is any injury or other tree		1 Burial 2 M Cremation 3 Bemoval from State	metery, crem	sition (Name of natory or other place g Cremato	7 72	Date	20c. Location - City of Smithsburg	Town, State
mit. F partme sorten / injur		21. Signature of Funeral Service Licensee	22.	. Name and Address	of Facility Sk		neral Home	-
permi Depar Impor any ir	_	23a. Part1. Enter the disease, or complications that caused the death.		0 West Ma			tsburg, Md.	21727
Physician		shock, or heart failure. List only one cause on each line.  Immediate Cause (Final				or respiratory a	11631,	Interval Between Onset and Death
/Medical Examiner		disease or condition resulting in death)  a.   Due to (or as a consequence)		01 142	2010			1129EARS
l be sit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	ence of):					
e execut ian and urial-tran	Examiner	that initiated events c.  The control of the contro	ence of):					
g physic as the b	edicai	d						
To the Hospitel or Attending Physicien: The law requires that the death certificate be executed within 24 brous after death.  To the Funerel Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director. page 2 should be detached for use as the burial-transit	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1			23d. Date of de Month	olivery Day Year		
s that	by Ph	Part II. Other significant conditions contributing to death but not resu	lting in the un	nderlying cause give	n in Part I.	23e. Did t	obacco use contribute t	to the cause of death?
require:	ted b					150	Yes 2 No 3 P	robably 4 Unknown
The law reger to has be	ompieted					24a. Was auto perfo		
cien: cien: ertifica ector. p	BeC	25. Was case referred to medical			26. Place of Death			2 2 140
nysic nysice nis ce	ToE	examiner?  1 Yes 2 No  Hospital: 1 Inpatient 2 E	R/Outpatien	t 3 DOA Othe	r. 4 ☐ Nursing Ho	me 5 Resi	dence 6 Other (Spe	ecify)
Attending Physicien: The laver dector: After this certificate has by the funeral director, page 2.		27. Manner of Death  1 Natural 5 Pending 2 Accident investigation  28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Work	at ? 'es 2 \sum No	28d. Describe	how injury occurred	
ol or Atte after deg Director	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At hor building, etc. (Specify,	me, farm, stre	eet, factory, office		28f. Location ( City or To	Street and Number or F wn, State)	Bural Route Number,
To the Hospitel or Attending I within 24 hours attended and to the Funerel Director: After completely filled in by the funer	edical C	29a. Certifier (Check only one)  Certifying Physician: To the best of my know 2 Medical Examiner: On the basis of examinati and manner stated.	vledge, death on and/or inv	n occurred at the time vestigation, in my op	e, date and place, inion, death occurr	and due to the red at the time,	cause(s) and manner a date and ptace, and du	s stated. e to the cause(s)
To the within To the	Me	29b. Signature and title of certifier.		29c. License	number / 76/		29d. Date signed (Mon	
ď		30. Name and address of person who completed cause of death (Item	23a) (Type,	Print)				
9				SEVENTY.	ST. FR	EDERICK	E MO 2	1701
Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's Signat	ше	-	/			
DHMH 17 Rev 1/2	001	<i>j</i> -5515 35	1					
			DRIGINA	\L				

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year Day Month **Physician** 0015 AM HERNANDE 2005 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** NORC If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 6. Sax (Ih yrs. last birthday 7. Age Number **Funeral** Hours 1⊠M 2□F 16 Director none 5/03/1988 Mexico Usual Residence of Decedent Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Pages 1 and 2 should be filed within 72 hours after death with the Maryla ment of Heath and Mental Hygiene.
snt: If Item 27 is marked other then "naturel", or Items 23e or 28e-1 shov ury or other treumatic event. The Medical Examinat must be notified at Baltimore 1X Yes 2 □ No Completed by Funeral Director MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 23 N.Chester Street 21231 Mexico 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 1 ☐ Yes 2 🔯 If Yes, Give Year or Dates: 1 Never Married 2 Married 2 No White Baltimore, Maryland 21215-0036 1X Yes 2□ No Specify: Mexican Specify 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) School Student 6 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ogadilla Franco Emilio Hernandez 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 23 N.Chester Street Baltimore, Md 21231 Fernando Franco/Uncle 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Guerrero, Mexico 4/22/05 permit. Page Depertment of Importent: If any injury or Guerrero, Mexico ' 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur of Funeral Service Licenses PATTOR AGESTIMALDI FUNERAL SERVICE, P.A. 9241 Columbia Blvd. Silver Spring, Md20910 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death BLAN HELMATION Immediate Cause (Final disease or condition resulting in death) Physician 3 Weeks /Medical Due to (or as a consequence of) **Examiner** 5.5 MM MENINGOTT Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) by Physician/Medical Examiner burial-transit to the Hospitel o. Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed certificate 2 No 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No P 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No after death. 2 Accident in by the f Director: 3 Suicide 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funerel C Dertifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier ical 29d. Date signed (Month, Day, Year) 29b. Signature and fifte of certifier 29c. License number 000 ٨ 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N BRADY 600 WOLFE BAITMORE, MD 21287 Registrar's Signature 31. Date filed (Month, Day, Year) State APR 13 Registrar

V.	
68760,	
-	
). Box	
s, P.O	
Records	
Vital	
J Of	
<b>Jivisior</b>	

			Please Type or Print in Black Indelible Ink		=		
			State of Maryland / Department of last State		∕lental Hy	giene	111 -
			1 - State Registrar Certificate of  1. Decedent's Name (First, Middle, Last)	Death	2. Date of De	Reg. No. 4 UU	3. Time of Death
	Physicia		Daniel Hayes Himes		Month April	Day Year	
	/Medic Examin			or Location of Death		4c. County of De	
	LAGITILI	) 	VA Maryland Health Care System Perry P	oint		Cecil	
5.7	. Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year 201 - 28 - 5781 1 🔀 M 2 🗆 F 6.9 Yrs Months Days		8. Date of Bir (Month, Da	rth 9. Bi	inthplace (State or Foreign Country)
	Director		201-28-5781 1 M 2 F 69 Yrs. World Says Usual Residence of Decedent				ennsylvania
	yland tow		10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
	e Mar a-fsh	ctor	Maryland Cecil Nort	th East			1⊠Yes 2□No
	or 28	Director	10e. Street and Number 10f. Zip Code	21901		10g. Citizen of What C	
	be filed within 72 hours after death with the Maryland tal Hygiene d other than *natural', or Items 23s or 28s-f show avent, I'm Medical Esaminar must be rotified at		11.2 Red Toad Road  11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of		acity Vac or No		sencan Indian,
_	fter de	Funerai	Armed Forces? If Yes, specify Cut	ban, Mexican, Puerto	Rican, etc.)	Black, Wh	
5	hours after tural', or ite	by	3 ☐ Widowed 4 🖾 Divorced If Yes, Give Year or Dates: 1954-57	Specify:		Specify:	White
9500-6121	72 hc	Completed	15. Decedent's Education 16a. Decedent's Usual Occu (Specify only highest grade completed) (Give kind of work done	e during most of work	king	16b. Kind of Busines	s/Industry
	within 72 ene. than *nat	dm	Elementary/Secondary (0-12) College (1-4or 5+) Ten Years Self-Employed	•	river	Tax	i Cab
70	filed Hygie other ent, t		17. Father's Name (First, Middle, Last)			, Maiden Sumame)	
land	lid be fental rked c	To Be	Earl Himes		Mam:	ie Hayes	
Mary	es 1 and 2 should be for the stand 2 should be for the standard the standard controller traumatic ever		19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Stree	at and Number or Rui	al Route Numb	er, City or Town, State,	Zip Code)
-	and 2 ealth m 27		Virginia Lawrence (sister) 709 Tait Str				
saltimore,	ges 1 It of H If Ite		20a. Method of Disposition  1 🗷 Burial 2 Cremation 3 Removal from State	ace)	Date	20c. Location - City o	
	it. Pa rtmen rtant: njury		^ 4 □Donation 5 □Other (Specify) Clermont Cemeter:  21. Signature of Funeral Service Licensee 22. Name and Addr		16/05	Clermont, F	ennsylvania
n n	permit. Pages 1 a Depurtment of He Important: If Item any njury or othe once.		The Lee A. Pa	tterson & e, Maryla	Son Fu	neral Home,	P.A.
	- 1		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dy shock, or hearf failure. List only one cause on each line.				Approximate Interval Between
I	Pnysician :		Immediate Cause (Final disease or condition a Cardiac arrythmia				Onset and Death unknown
	/Medical Examiner		resulting in death)  Due to (or as a consequence of):				dimilowii
	- xammer	_	Sequentially list conditions, if any, leading to immediate b. Coronary Artery Disease  Due to (or as a consequence of):				unknown
	ted nsit	nine	cause. Enter Underlying	.1.			
,	be executed ician and burial-transit	Examiner	c. Cerebral Vascular Acciden  c. Due to (or as a consequence of):	.L.			unknown
760			d. Liver Cirrhosis				unknown
99 )	death certificate e attending phys ed for use as the	Physician/Medical	IF FEMALE:			1-	
ROX	ath ce	ian/	23b. Was decedent pregnant  1 Live birth 2 Fetal death 3 Ectopic pregnancy	су		23d. Date of de Month	elivery Day Year
	0 0	ysic	1   Yes 2   No 9   Unknown   4   Pregnant at time of death 5   Other (specify)   9   Unknown				
J.	The law requires that the the bas been signed by the bage 2 should be detached.	by Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause gr	iven in Part I.	23e. Did t	tobacco use contribute	to the cause of death?
rds	w requires been sign should be				10	Yes 2□No 3□F	Probably 4 Dunknown
Records,	law reas blee	ompleted			24a. Was	an 24b. Were a	autopsy findings available completion of cause of
Ĭ		Соп			perfo 1 ☐ Yes	ormed? death? 2≦No 1 ☐ Ye	s 2 No
Vital	Physician: r this certific ral directo ,	Be	25. Was case referred to medical examiner?  Hospital:	26. Place of Deat			
o	Phy rthis ral d	5	1   Inpatient 2   EH/Outpatient 3   DOA			dence 6 Other (Sp.	ecify)
on	nding F th. : After s funer	tion	1X Natural 5 Pending (Month, Day Year) Injury Wo	ork? ]Yes 2 □No			
Division	Attendi er death. ector: A by the fu	Certification:	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	•	28f. Location (	Street and Number or F	Rural Route Number,
ō	ital or rs afte ral Dii led in	Cer			ŕ		
	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the fune	ledical	29a. Certifier  (Check only one)  Certifying Physician: To the best of my knowledge, death occurred at the term of examination and/or investigation, in my one)	time, date and place, opinion, death occur	and due to the red at the time,	cause(s) and manner a date and place, and du	as stated. e to the cause(s)
	ithin 2 o the	Med		nse number		29d. Date signed (Mor	nth, Day, Year)
	⊢ ≯ ⊢ ŏ		Tomula my D302	.72		4/12/05	
	ex 10		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)			, . <del></del>	
	1		Thomas Miller, M.D. VA Maryland health Care	System Pe	erry Po	int, MD 21	.902
	Sta Registr		31. Date filed (Month, Day, Year) APR 1 5 2005				
	Liedian		TO COOS MANAGEMENT TO				

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registre Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2:25 PM **Physician** Glenna Mae Johnson 2005 Haril /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b City Town or Location of Death Examiner Washington County Hospital Washington County Hagerstown If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Days 1 M 2 XF Months Hours 53 Yrs Director April 1952 220-52-1231 Maryland Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10h County 28a-f ahow other traumatic event, the Medical Examiner must be notified at TY Yes 2 □ No Director Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 21740 United States 238 23 Madison Ave. Completed by Funeral Pages 1 and 2 should be filed within 72 hours after death anent of Health and Mental Hygiene. Int: If item 27 Is marked other than "natural", or Itams 23. 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Saltimore, Maryland 21215-0036 Specify: White Specify 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 10 BD of Education Crossing Guard 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be ဥ Hillard F Grove Sr. Doris V. Socks 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 23 Madison Ave. Hagerstown Maryland 21740 Wayne E. Johnson, Sr. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State ö Smithsburg Crematory Apr 19 2005 permit. Page Depirtment of Important: If any Injury or once. \* 4 ☐ Donation 5 ☐ Other (Specify) Smithsburg Maryland 22. Name and Address of Facility Douglas A. Fiery Funeral Home 21. Signature of Funeral Service Licensee 1331 Eastern Blvd. N. Hagerstown Maryland 21742 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fagure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician RESMITATOR /Medical Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner The law requires that the death certificate be executed burial-transi Due to (or as a consequence of) Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 2XNo 1 Yes Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Hospital: 2 ER/Outpatient 3 DOA 2 1 Inpatient 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: After 5 Pending investigation Natural death. М 1 Tyes 2 🗆 No 2 Accident Diractor 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 \ Homicide within 24 hours a To the Funaral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

State Registrar Dr

Hatleberg 31. Date filed (Month 32. Registrar's Signature 9

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

11110

Medical

DHMH 17 Rev 1/2001

27949

Campus Rd

Hagerstown, Maryland

			For State Registrar		ryland / Dep		Health and N	Mental Hy	giene 0 5	14493
			1. Decedent's Name (First, Middle, Last)					2. Date of Dea	ath	3. Time of Death
46	Physici /Medio		John Frederich	Krasny				April	7 <sup>Day</sup> 2005 <sup>Year</sup>	10:35 А.м
*	Examir		4a. Facility Name (If not institution, give s			4b. City, Town, o	or Location of Death	1	4c. County of Dear	th
			419 Russell Avenue			Gaither	_		Montgome	ery
	Funeral Director		5. Social Security Number 6. Sex 059-14-7532	7. Age	90 Yrs.	If Under 1 Year Months Days		8. Date of Birt (Month, Da October	v, Year) _ Co	thplace (State or Foreign ountry) stria
	Maryland -f show	tor	10a. State 10b. County Maryland Montgomer	У	10c. City, Town or L Gaithers.					10d. Inside City Limits 1 X Yes 2 □ No
	h with the 23a or 28a st be roti	al Director	10e. Street and Number 419 Russell Avenue	#302		10f. Zip Code 208	377		10g. Citizen of What Co	
036	I be filed within 72 hours after deeth with the Maryland nial Hygiene. ed other then "natural", or Items 23a or 28a-f show event, the Medical Examinar must be notified at	by Funeral	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 ☑ Yes 2 ☐ N If Yes, Give Year or Dates:	ver in U.S. 13.	Was Decedent of I If Yes, specify Cub 1 ☐ Yes 2 ☑ No	Hispanic Origin? (Span, Mexican, Puend Specify:	pecify Yes or No- Dican, etc.)	14. Race - Ame Black, Whit Specify: W	e, etc.
Maryland 21215-0036	thin 72 ho e. en "naturi Medical I	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	cation completed) College (1-4or 5	+) (Give	DO NOT use retire	during most of world)	king	16b. Kind of Business	Industry
21	filed wi Hygien other th	Cou		5+	Text:	ile Scie	entist		Textile	
yland	should be filed on the marked other imatic event, it	To Be	17. Father's Name (First, Middle, Last)  Arnold Krasny					ne (First, Middle, ne Sobot	Maiden Sumame) ka	
, Mar	and 2 sho alth and 127 is m		19a. Informant's Name/Relationship (Type Mary Krasny/ Wife	oe, Print)					r, City or Town, State, 2 ersburg, MI	
Baltimore,	ages 1 gant of He at: If item		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ R  1 ☐ Other (Specify)	emoval from State	20b. Place of Disponsion Commetery, cred	matory or other pla Univer:	51 L.V : -	il 7	20c. Location - City or Washington	
Baltin	perrait. Pages 1 and 2 should by Department of Health and Menta Importent: If item 27 is marked any niury oc. office treumatic energy injury oc. office is any niury oc.		21. Signaturi ov Funeral Prvice Licen	Jud	Medical	Center  2. Name and Addre  P.(	20 ess of FacilityCol.  D. Box 58	umbia Mc 007 Wash		vices, Inc. C. 20037
	Physician /Medical		23a Part : Enter the disease, or complice shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	Congest	the death. Do not ene.  ive Heart a consequence of):		ng, such as cardiac	or respiratory ar	rest,	Approximate Interval Between Onset and Death 2 Years
,092	physician and physician and sthe burial-transit	Ical Examiner	Sequentially liet or different if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last	Coronal Due to (or as a	ry Artery a consequence of):	Disease				8 Years
.O. Box 68	requires that the death certificat, nean signed by the attending phy hould be detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of a line of the state	2 Fetal death 3	Ectopic pregnanc Other (specify)	у		23d. Date of del Month	ivery Day Year
ds, P.	uires that signed b ld be deta	by	Part II. Other significant conditions con Hypertension	tributing to death bu	it not resulting in the u	inderlying cause gr	ven in Part I.		ibacco use contribute to les 2 □ No 3 □ Pr	
CO	w requir been si should	lete	Hyperlipidemi	la				24a. Was	an 24b. Were au	topsy findings available
	icien: The law r certificate has be ector, page 2 sh	Completed	Prostate Cance	er				autop perfor 1  Yes	sy prior to death? 2 ★No 1 Yes	completion of cause of
Š		o Be	25. Was case referred to medical examiner?	ospital:		Ott	26. Place of Dear			
ō	ding h. After fune	1	1 Yes 2 XNo  27. Manner of Death  1 XNatural 5 Pending 2 Accident investigation	28a. Date of Injur (Month, Day	nt 2 ER/Outpatien y 28b. Time of Injury	f 28c. Inju	ry at	28d. Describe h	ence 6 Other (Specow injury occurred	cify)
Division	el or Attences after death	Sertification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injubulding, etc.	ry - At home, farm, st . (Specify)	reet, factory, office		28f. Location (S City or Tow	treet and Number or Run, State)	ıral Route Number,
	To the Hospitel or Atte within 24 hours after de To the Funerel Directo completely filled in by th	edical C	29a. Certifier 1 ★ Certifying Phys (Check only one) 2 ★ Medical Examin	sician: To the best of ner: On the basis of and manner sta	examination and/or in	h occurred at the ti	me, date and place, opinion, death occur	and due to the orred at the time, or	ause(s) and manner as late and place, and due	stated. to the cause(s)
	To the within To the comp	M	29b. Signature and title of certifier	. Of	Es MA	29c. Licens D0050			29d. Date signed (Monti April 12,	**
		B	30. Name an dress of person who co Brian C. Shen, M		eath (Item 23a) (Type, North Fre		menue. Ga:	ithersbu	rg, MD 208	377
	Sta Registi		31. Date filed (Month, Day, Year)  APR 1 3 206		r's Signature		, ,			<del> </del>

			For State Registrar	State of N	/larylan		artment of			ental Hygi	ene		11.1.91.
			Registrar  1. Decedent's Name (First, Middle	lo Lasti		Cei	rtificate o	T Death		Re 2. Date of Death	g. No	00	3 Time of Dooth
ı	Physicia	an								Month	Day	Year	3. Time of Death
	/Medic Examin		Andrew 4a. Fecility Name (If not institution	Omarinski n. give street and numbe	r)		4b. City, Town	, or Location		April	16 4c. County	2005 of Death	7:10 P M
	Examili	e i	220 Sunbrook		•			gersto				shing	ton
	Funeral		5. Social Security Number	6. Sex 7. /	Age (In yrs.	last birthday)	If Under 1 Year Months Day	ar If Under	24 Hrs. 8	3. Date of Birth (Month, Day June 29		9. Birthp	lace (State or Foreign
	Director		163-24-2737	1 <b>X</b> ]M 2□F	75	Yrs.	Wortins Day	3 Hours	.VIII.	June 29	,1929	Penn	sylvania _
	and **		Usual Residence of Decedent  10a. State 10b. County	,	10c. Cit	y, Town or Lo	ocation					1	0d. Inside City Limits
	Aaryle f sho	ŏ				•	gerstow	n					1XXYes 2 □ No
	the 1	rect	Maryland Wasi 10e. Street and Number	nington		116	10f. Zip Code			10	g. Citizen of	What Cour	ntry?
	3a ol	ie D	220 Sunbrook	lane				21742				USA	
	deatl	ner	11. Marital Status	12. Was Deceder Armed Force		.S. 13.	Was Decedent of If Yes, specify Co			ify Yes or No-		e - Americ	an Indian,
9	or ite	by Funeral Director	1 Never Married 2 Mar	ried 1 ☐ Yes 2 5	∮ No		1 □ Yes 2 ☑ N				Specif		BIG.
21215-0036	within 72 hours after death with the Maryland ene. than *neturel', or items 23e or 28e-f show he Medical Examiner must be notified at	q p	3 Widowed 4 Divorced	Year or Dates	S:							W	hite
5	n 72 n * net	Completed	(Specify only highe	nt's Education est grade completed)		(Give	dent's Usual Occ kind of work dor DO NOT use reti	upation ne <i>during m</i> os <i>red</i> )	t of working	, '	6b. Kind of B	usiness/in	dustry
212	with jene. r thar	omb	Elementary/Secondary (0-12)	College (1-4d	r 5+)		ne Set				Truck	Manuf	acturer
	e filec al Hyg othe vent,	Be C	17. Father's Name (First, Middle,	Last)				18. Mothe	er's Name (	First, Middle, M	leiden Surnan	ne)	
ylaı	ould b Menta arked	Tof	Frank Kor	marinski, Sı	٠.			An		Lesczi			
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene. Importent: If item 27 is marked other than "neturel", or items 33a or 28a-1 show eny injury or other treumatic event, the Medical Examinat must be notified at once.		19a. Informant's Name/Relations			1	ng Address (Stre						Little To Land
	1 and 1ealth Im 27 Ther to		Dorothy Komar 20a. Method of Disposition	inski-Wite	20h P		Sunbroo		Hage	-	Oc. Location		21742
Baltimore,	ages or of		1 Burial 2 Cremation	3 □Removal from State	0	emetery, crer	sition (Name of matory or other p	lace)		4.			t,Maryland
Ē	it. Partmer intmer injury it.		' 4 □ Donation 5 ★ Other (S	1 -1	eni Gr		Spalle Spalle			_	WIIIIG	iiispoi	1,Mai y land
Ba	Depar Depar Impos eny ir		lean 1	7-09_	_						lliams	port,	MD 21795
			23a. Part1. Enter the diseese, or shock, or heart failure. List	r complications that caus only one cause on each	ed the deati line.	h. Do not ent	er the mode of d	ying, such as	cardiac or i	respiratory arre	st,		Approximate Interval Between Onset and Death
E	Pnysician		Immediate Cause (Final disease or condition resulting in death)	a	Lun	, (	incer					- 4	16 months
	/Medical Examiner		resulting in dealin)	Due to (or a	is a conseq	uence of):							
		-	Sequentially list conditions,	b. Due to (or a	s a conseq	uence of):						- 6	
	uted 3 ansit	Examiner	if any, leading to immediate cause. Enter Undertying that initiated events	<									
oʻ	te be executed ysician and e burial-transit		resulting in death) Last	Due to (or a	as a conseq	uence of):					• •		
8760,		ical		d									
9	as as	Physician/Med	IF FEMALE:	23c. If yes, outcom	o of aroona							1	
Вох	aath cer attendin for use	ian	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth	2 🔲 Feta	Ideath 3□	Ectopic pregnar Other (specify)	псу				te of delive nth	ry Day Year
P.O.	that the death ned by the atter detached for u	ysic	1 □ Yes 2 □ No 9 □ Unknown	9☐ Unknown									
	law requires that the as been signed by th 2 should be detache	by Pi	Part II. Dther significant conditi	ons contributing to death	but not res	ulting in the u	nderlying cause	given in Part I		23e. Did tob	acco use cont	ribute to th	e cause of death?
ğ	w require been sig should b	edt								1 ⊡ Yes	s 2□No	3 Prob	ably 4 \textcal Unknown
Records,	e law re has bed je 2 sho	Completed								24a. Was an autopsy	24b.	Were auto	psy findings available inpletion of cause of
Ĕ	The ate ha page	Com								perform	ed?_	death?	2□ No
/ita	Physicien: this certific ral director,	Be	25. Was case referred to medica examiner?	Hospital:					of Death (	Check only one	)		
of	Physical dir	۲: ا	1 Yes 2 No	i 1 ∐ Inpa		ER/Outpatien 28b. Time of	IL 3L DON	- Advantage -		<ul> <li>5 ☑ Resider</li> <li>d. Describe how</li> </ul>			/)
on	ding h. After fune	tion	1 Natural 5 Pendir 2 Accident investi		Day Yeer)	Injury	W	ork? □Yes 2 🗀		a. 50001150 1101	·quiy oodu		
Division of Vital	il or Attending after death. I Director: After d in by the fune	ifica	3 Suicide 6 Could	not be 28e. Place of I	njury - At ho	ome, farm, str	eet, factory, offic	е	28	f. Location (Str	et and Numb	er or Rura	l Route Number,
ā	s afte	Certification;	4 Homicide	building,	etc. ( <i>Specif</i>	y)				City or Town,	State)		
	To the Hospital or Attending Physicien: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Medical		ng Physicien: To the bea Exeminer: On the basis and manner	of examina								
	To the To the Comple	Me	29b. Signature and title of certifie	0 0				nse number			d. Date signe		-
)			Muchael	J. Thule	m	_ Me	0	4166	7		4.	18.0	05
5	H-8		30. Name and address of person Michael				Print)	redic	1 (	inger	be so	repru	~ MO
	Sta Registr		31. Date liled (Month, Day, Year,	9 2005 32. Refin	strar's Signa	ture	110 N						

		_1	For State of Man		artment of Hertificate of L		Re	eg. No.2 UU5	14495
	Physicia /Medica	n al -	1. Decedent's Name (First, Middle, Last)  JACK K. KREUTZER		r-		2. Date of Death	6, 2005	3. Time of Death
	Examine		Na. Facility Name (If not institution, give street and number) WASHINGTON COUNTY HOSPITAL	(	4b. City, Town, or HAGE If Under 1 Year	RSTOWN  If Under 24 Hrs.	To Date of Birth	4c. County of Death WASHINGT(	N
	Funeral Director		5. Social Security Number 6. Sex 7. Age (I	n yrs. last birthday) 83 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, 10/11/	Year) 9. Birth Cou 1921 MAF	place (State or Foreign ntry) RYLAND
	Maryland f show			Oc. City, Town or La	cation GESVILLE				10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	with the I	ਰ ਹ	10e. Street and Number 603 CONSILER LANE		10f. Zip Code 254	27	10	0g. Citizen of What Cou	ntry?
036	ors a	by Fur	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent Ever Armed Forces?  1 Never Married 2 Married  11. Was Decedent Ever Armed Forces?  1 Never Married 2 No If Yes, Give Year or Dates:		Was Decedent of His If Yes, specify Cubar 1 ☐ Yes 2 ☒ No		pecify Yes or No- p Rican, etc.)	14. Race - Ameri Black, White,	
Baltimore, Maryland 21215-0036	d within 72 ho giane. rr than "nature the Medical I	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)	(Give	dent's Usual Occupa kind of work done d DO NOT use retired) VER/OPERAT	uring most of work	sing	16b. Kind of Business/Ir RESTAURAI	
land	uld be file fental Hyg rked othe tic event,	To Be C	17. Father's Name <i>(First, Middle, Last)</i> HENRY F. KREUTZER				e (First, Middle, M	faiden Sumame)	
Mary	alth and N 27 Is ma or trauma		19a. Informant's Name/Relationship ( <i>Type, Print</i> ) PATRICIA KREUTZER / WIFE					City or Town, State, Zip LE WV 25427	
more,	Pages 1 and of Heren of Heren It is it is the into the into or other int		20a. Method of Disposition  1 □ Burial 2 ☑ Cremation 3 □ Removal from State  1 □ Donation 5 □ Other (Specify)	20b. Place of Dispo cemetery, crer SMITHSBURG	natory or other place	-)	7.10005	20c. Location - City or To SMITHSBURG	
Balti	permit. Departm Importa any inju		21. Signature of Funeral Service Licensee  Charles M. Brown	22	2. Name and Addres			XAL HOME, P.O. ISBURG WV 2540	
8760,		Exal	0		iratory	Prist	ress 5	gud rome	Inierval Between Onset and Death I O d wy S
Вох 6	The law requires that the death certifica ate has been signed by the attending ph page 2 should be detached for use as the	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  23c. If yes, outcome of 1 ☐ Live birth 2 [ 4 ☐ Pregnant at tim	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of deliv Month	ery Day Year
ords, P.		Completed by Ph	Part II. Other significant conditions contributing to death but of Chronic Oss Tructure	Curry	nderlying cause give		1 □ Ye	/	bably 4 □Unknown
/ital Rec	cien: The law ertificate has b octor, page 2 s		Cinhosis & Liver.  25. Was case referred to medical examiner?	nent	causn		1 Yes	No 1 Yes	opsy findings available ompletion of cause of
Division of Vital Records, P.O.	or Attending P ifter death. Director: After t in by the funera	Certification: To	27. Manner of eath  1 Yes 2 No  27. Manner of eath  1 Natural 5 Pending investigation  3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury building, etc. (		f 28c. Injury Work M 1 \(\sum \)	at at	28d. Describe ho	reet and Number or Run	
	the Hospitel hin 24 hours a the Funeral I npletely filled	Medical Ce	29a. Certifier (Check only one)  Certifying Physician: To the best of representation of the basis of examiner: On the basis of examiner states.	camination and/or in	h occurred at the tim vestigation, in my op	e, date and place, inion, death occur	and due to the ca red at the time, da	use(s) and manner as s ate and place, and due t	stated. o the cause(s)
	To the within 24	ž	29b. Signature and title of certifier  May & May & May		29c. License	number 38/5	25	Pri/IC	Day, Year) 2005
SH:	-3+/ Stat		30. Name and address of person who completed cause of deal Mary E: Money 35  31. Date filed (Month, Day, Year) 8 2005  32. Pigistrar's	th (Item 23a) (Type,	Print) (54res	et, He	cselsi	town, m	2005 D 21740

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death April 11, Day 2005 Year **Physician** Karoly KLEIN 5:20 P M /Medical 4e. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hebrew Home of Greater Washington Rockville Montgomery | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month Day), Year | June 18, 1913 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplece (State or Foreign **Funeral** 1 M 2□ F 91 214-25-8806 Romania Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene sant: If Item 27 is marked other then "natural", or Items 23e or 28e-f show ary or other traumatic event. Its Modical Examinational and other traumatic event. Its Modical Examinational and a collection and the notified at 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 → No Maryland Bethesda Montgomery Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20817 10250 Westlake Drive United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ₹ No Specify: Specify: white þ 3 Widowed 4 Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Warehouse Manager Agriculture 4 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Avrum Klein Maria Grunn ۲ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael Klein, Son 7400 Bradley Blvd., Bethesda, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages 1
Department of H
important: If its
any injury or ot 1 Burial 2 Cremation 3 Removal from State \*4 ☐ Donation 5 ☐ Other (Specify) 04/13/05 New Light Cemeterv Pittsburgh, PA 21. Signature a Funeral Service Lice see Torchinsky Hebrew Funeral Home 254 Carroll St., NW, Washington, DC 23a. Part Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death tmmediate Cause (Final disease or condition resulting in death) **Physician** osstrutive Chronic /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran and Due to (or as a consequence of) Box 68760. attending physician Physician/Medical as the IF FEMALE use 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month jo Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. the 9 Unknown Š signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Waknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 performed? certificate 1 ☐ Yes 2 ☐ No 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 tnpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No Certification: To this funeral 27. Manner of Beath 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred ieral Director: After filled in by the funer 1 [HNatural 5 Pending investigation 1 ☐ Yes 2 ☐ No death 2 Accident 6 Could not be 3 🗌 Suicide 28e. Place of tnjury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours after To the Funeral Dire territying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) P5525-8 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Gary Wilks, M.D. Maryland Road Rockville Montese 20852 31. Date filed (Month, Day, Year) APR 1 4 2005 Registrar

LOS	JIMENE	_	LOPEZ  State Registrar	State of	Maryla	nd / Depa <i>Cei</i>	artmen <i>tificat</i>			and M		giene	200	5 11.1.0	~ <sub>1</sub>
	Physici	an	1. Decedent's Name (First, Middle Carlos	Jimene	7	Lopez					2. Date of Dea Month		Ye		1
	/Medic Examin		4a. Fecility Name (If not institution 5311 GREENWAY			поред	4b. City,	Town, or VERD	Location o	of Death	APRIL		2005 County of D RINCE	· · · · · · · · · · · · · · · · · · ·	
	Funeral Director		5. Social Security Number none	6. Sex 7. 1 ★M 2 ☐ F	. Age (In yrs	s. last birthday) Yrs.	If Under Months	1 Year Days	If Under 2 Hours	24 Hrs. Min.	8. Date of Birth (Month, Day 1 1 / 0 2	h y, Yeer) <b>/19</b> 7		Birthplace (State or Foreig Country) EXICO	n
	be filed within 72 hours after death with lhe Maryland ital Hygiene. id other than "naturel", or items 23s or 28s-f show other than "naturel", or items 23s or 28s-f show event, the Madical Examiner must be notified at	irector	10e. Street and Number	ce George	's	Hyatt		Code				10g. Citiz	en of What	10d. Inside City Limits 1 ☐ Yes 2 🔀 No	
	death with	Funeral Director	3517 Toledo	Terrace  12. Was Deced Armed Force	ent Ever in	U.S. 13.	Vas Deced	207		gin? (Spe	cify Yes or No- Rican, etc.)	. 1		merican Indian,	
9600	nours after urel', or ite	þ	1 Never Married 2 Marri 3 Widowed 4 Divorced	ed 1 ∏Yes 2 If Yes, Give Year or Dat	IX No		X Yes	2 🗆 No	Specify:		kican	5	Specify:	White	
1215-	within 72 t ene. than "nate	Completed	15. Decedent (Specify only highes Elementary/Secondary (0-12)	's Education it grade completed) College (1-4	for 5+)		kind of wo DO NOT us	rk done d se retired,	ution Juring most orke:		ng		<sub>d of Busine</sub> istru	estion	
Maryland 21215-0036	12 should be filed within "and Mental Hygiene. Fis marked other than "raumatic event, the Mac	0	17. Father's Name (First, Middle, Raymundo Jime						18. Mothe	r's Name	(First, Middle, Lopez	Maiden S	Sumame)		
	permit. Pages 1 and 2 should be Department of Health and Menta importent: if item 27 is marked any injury or other traumatic as once.		19a. Informant's Name/Relationsh Susana Jimene		•		_				Route Numbe O Hyat			e, Zip Code) Md 20782	I
Baltimore,	Pages 1 ament of He ent: if item ury or oth		20a. Method of Disposition 1   Burial 2 □ Cremation 1 □ Donation 5 □ Other (Sp		ate	Place of Dispo cemetery, cren eracru	natory or o	ther place	· A	/26,	/ 0 5			or Town, State IZ, Mexico	
Balt	permit. Departi import any inj		21. Signature Wuneral Service I	Cully		9	241	Col	umbi	a B	lvd.Si	lver	SERV Spr	ICE,P.A. ing,Md2091	10
ł	Physician /Medical		23a. Part 1. Enter the disease, or shock, or heart/ailure. List Immediate Cause (Final disease or condition resulting in death)	a		nging	er the mod	e of dying	g, such as	cardiac d	r respiratory ar	rest,		Approximate Interval Between Onset and Death	
8760,	rate be executed by the burial-transit and th	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last	с.		equence of):									
P.O. Box 68	ne death certific the attending p	by Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		h 2 ☐ Fe nt at time of	tal death 3	Ectopic pr Other (sp		12.1			23	3d. Date of Month	delivery Day Year	
rds, P.	w requires that the base of the control of the cont	ed by Pr	Part II. Other significant condition	ns contributing to dea	th but not re	esulting in the ur	nderlying c	ause give	n in Part I.		23e. Did to			e to the cause of death?  Probably 4 □Unknown	1
Division of Vital Records,	The law ate has b page 2 sl	Completed									24a. Was autop pertor 1 N Yes	SV	24b. Were prior death 1 X Y	autopsy findings available to completion of cause of ?? 'es 2 \( \) No	•
f Vita	Physicien: Th this certificate al director, pag	To Be	25. Was case referred to medical examiner?  1   Yes 2   No	Hospital: 1 🗆 Ing		☐ ER/Outpatien			<sup>©</sup> 4□ Nui		(Check only o		<b>X</b> other (S	pecify) AT SCEN	E
sion o	ter ner	Certification:	27. Manner of Death  1 Natural 5 Pending 2 Accident investig 3 Suicide 6 Could r	jation tound 4-	11-05	10:45	ÅМ		at ? /es 2 💢 1	No		han	ged .	himself	
Divi	To the Hospitel or Attendir within 24 hours after death. To the Funeral Director: Al completely filled in by the fu	Certifi	4 Homicide determ	ined 288. Place o	j, etc. (Spec	park					City or Ton 2: verdal	n, State)	53110	Greenway Briv	2
	he Hosp in 24 hou he Fune pletely fi	edicai	29a. Certifier 1 ☐ Certifyin (Check only one)	g Physician: To the b Examiner: On the bas and manne	is of examin	nowledge, death nation and/or in	occurred restigation	at the tim , in my op	e, date and inion, deat	d place, a th occurre	and due to the code at the time, of	ause(s) a date and p	and manner place, and c	as stated. due to the cause(s)	
	To t To t	Σ	29b. Signature and title of certifier	, m.D			290	. License	number ME				signed (Mo $^{12}$ ,	onth, Dey, Year) 2005	
	1		30. Name and address of person	_	of death (Ite	эт 23а) (Туре,		.11 P	enn S	Stree	et Balt	imor	e, Ma	ryland 21201	
	Sta Registr	- 4	31. Date filod (Month, Day, Year)		gistrar's Sign	B Ap							,		

			State of Maryland / Department of Health and M  1- State Registrar Certificate of Death		0000	11100
				2. Date of Dea	eg. No.	3. Time of Death
	Physicia	ın	1. Decedent's Name (First, Middle, Last)	Month	Day Year	
3	/Medic	al		April	12 2005	10:25 P <sup>M</sup>
	Examin	er			4c. County of Dea	
			Montgomery General Hospital Olney  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.	8. Date of Birth	Montgome	
	Funeral		1 M 2 X F Months Days Hours Min.	(Month, Day	, Year) C	thplace (State or Foreign ountry)
	Director		578.28.0926 85 Yrs. Usual Residence of Decedent	July 16	, 1919   Pe	nnsylvania
	land ow		10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
	Mary 1 sh	į	Maryland Montgomery Silver Spring			1X1Yes 2 ☐ No
	the 28a	Director	10e. Street and Number 10f. Zip Code	1	I0g. Citizen of What C	ountry?
	3e or		15004 Candover Court 20906	1	United Stat	tes
	death	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Spe	cify Yes or No-	14. Race - Am	erican Indian,
(0	or Ite	Fu	Armed Forces? If Yes, specify Cuban, Mexican, Puerto  1 □ Never Married 2 □ Married 1 □ Yes 2 ☒ No	Hican, etc.)	Black, Whi	
8	al', o	by	3 ☐ Widowed 4 ☑ Divorced If Yes, Give 1 ☐ Yes 2 ☒ No Specify:		Specify: W	hite
9	72 ho	Completed	15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of work)	na	16b. Kind of Business	/Industry
2	thin e.	ple	Elementary/Secondary (0-12) College (1-4or 5+)		Washington	n Adventist
7	arth.	Son	1 Year Head Cashier		Hospital	
ng	be filed within 72 hours after death with the Maryland the lygiene. The lygiene did other than "natural", or items 23e or 28e-f show avant, the Medical Francisci must be indiffed at	Be	17. Father's Name (First, Middle, Last)  18. Mother's Name		Maiden Surname)	
Maryland 21215-0036	Ment Ment arke	°		Sabol		
ar	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or items 23e or 28e-1 show amy injury go other traumatic avant, the Medical Evander interior confiled at any once.		19a. Informant's Name/Relationship ( <i>Type, Print</i> )  19b. Mailing Address ( <i>Street and Number or Rura</i>			
≥,	and ealth n 27 ner tr		Donna L. Hall/Daughter 1425 Silo Way, Silver			
Baltimore,	of H of H if itar		20a. Method of Disposition 1 □ Burial 2 ☑ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or	Town, State
<u>Ĕ</u>	Pag ant: 1		'4 □Donation 5 □Other (Specify)   Fort Lincoln Crematory 4/1			
at	port port y inj		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hin			
m	8 9 E 2		Norman A. Vaccondo 11800 New Hampshire			g MD 20904
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac c shock, or hear failure. List only one cause on each line.	or respiratory arr	rest,	Approximate Interval Between
Į.Ų	Physician		Immediate Cause (Final disease or condition a Congestive Heart Failure			Onset and Death  3 Years
	/Medical		resulting in death)  Due to (or as a consequence of):			_J_Teals
	Examiner		Sequentially list conditions, Hypertension			20 Years
_	P ==	ner	Gause (Disease or injury  Due to (or as a consequence of):  Cause (Disease or injury  Coronary Artery Disease			
	cutec nd ransi	Examiner	that initiated events c.			20 years
ó	e exe ian a ırial-i	Ĕ	resulting in death) Last Due to (or as a consequence of):			
8760,	icate be executed physician and s the burial-transit	dical	d			
9	ing pl	Med	IF FEMALE:			
Вох	th ce tendi	an/l	23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy  1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy		23d. Date of de Month	livery Day Year
O.	e dea he at	Sici	1 Yes 2 No			24)
<u>Ч</u>	The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	by Physician/Me	9 Unknown  Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23a Did to	bacco use contribute t	o the cause of death?
	res tha igned be de	by	Diabetes			robably 4 Dunknown
ord	w requir been si should	Completed		101		
Vital Records,	e taw has b	) ple		24a. Was a autops	sy prior to	utopsy findings available completion of cause of
<u>ш</u>		Cou		perfor 1 ☐ Yes	med? death? 2 ☑ No 1 ☐ Ye	s 2 No
/ita	Attanding Physician: Thr death. soctor: After this certificate	Be	25. Was case referred to medical examiner?	(Check only or	10)	
<u>}</u>	Physic this c	P			ence 6 Other (Spe	ecify)
n	ng P	on:	1 XNatural 5 □ Pending (Month, Day Year) Injury Work?	28d. Describe h	ow injury occurred	
sio	tandi eath. or: A the fu	catl	2 Accident investigation 3 Suicide 6 Could not be 280 Risce of Injury 4t home farm street factory office			
Division of	or Ati	Certification;	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28t. Location (S City or Tow	treet and Number or R n, State)	lural Houte Number,
	To the Hospital or Attanding Physimithia 24 hours after death.  To the Funeral Director: After this of completely filled in by the funeral difference of the funeral differenc				(-)	
	Hosi 14 hoi Funa Tely fi	edical	29a. Certifier    Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, condition of examination and/or investigation, in my opinion, death occurred to the basis of examination and/or investigation, in my opinion, death occurred to the basis of examination and/or investigation, in my opinion, death occurred to the basis of examination and/or investigation, in my opinion, death occurred to the basis of examination and/or investigation, in my opinion, death occurred to the basis of examination and/or investigation, in my opinion, death occurred to the basis of examination and/or investigation, in my opinion, death occurred to the basis of examination and/or investigation, in my opinion, death occurred to the basis of examination and/or investigation, in my opinion, death occurred to the basis of examination and/or investigation, in my opinion, death occurred to the basis of examination and/or investigation, in my opinion, death occurred to the basis of examination and/or investigation, in my opinion, death occurred to the basis of examination and/or investigation, in my opinion, death occurred to the basis of examination and/or investigation.	and due to the c ed at the time, d	ause(s) and manner a late and place, and du	s stated. e to the cause(s)
	tha thin 2 tha mplet	Med	29b. Signatu(e) and title of certifier 29c. License number	1 3	29d. Date signed (Mon	th. Day. Year)
	T Will	-	100 331 or		(4 12/A	5
7	210			l	7 11310	
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Adolph Johnson, M.D., 12520 Prosperity Drive, #150, S	ilver C	nring. MD	
				TTACT D	F-1116, 1110	
	Sta Registi		31. Date filed (Month, Day, Year)  APR 1 4 2005  37 Registrar's Signature			

Please Type or Print in Black Indelible Ink	. Ensure All Copies Are Legible.
---	----------------------------------

		For State Registrar	State of M	aryland / Depa <i>Ce</i>	artment of H		nd Mental Hy	/giene	05	9722	. 0.0
Dhuai	ion	1. Decedent's Name (First, Middle, L	•				2. Date of D	10-0 1-1	Year	3. Time of	Death
Physic /Med		Charles Powell					04	08 20	005	2:15	P M
Exam	iner	4a. Facility Name (If not institution, g			4b. City, Town, or		Death		ty of Death		
Former		Westminster Hos 5. Social Security Number 6.		je (In yrs. last birthday)	Westmins  If Under 1 Year		4 Hrs. 8, Date of B	Carı		olace (State or	r Foreign
Funera Directo		578-10-2442	1 M 2 □ F	97 Yrs.	Months Days	Hours	4 Hrs. 8. Date of B (Month, D	1907	Virg:	itry)	7 Groigii
pu ,		Usual Residence of Decedent		10c. City, Town or Lo							
the Marylar 28a-1 show	2	10a. State 10b. County MD Carro1	1	Eldersbu					1"	0d. Inside Cit 1 X Yes	
the N	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of	What Cour		
3e or	I Di	421 Ronsdale Roa	d		21784			United			
deatl	Funeral	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S. 13.		ispanic Origii	n? (Specify Yes or N Puerto Rican, etc.)		ice - Americ	an Indian,	
36 after after	by Fu	1 Never Married 2 Married	1 X Yes 2 ☐ If Yes, Give	No WW LL I	1 ☐ Yes 2 🛣 No	Specify:	r dotto r nouri, oto.,		<sub>ify:</sub> Whit		
hours tural	q pa	3 ☐ Widowed 4 ☐ Divorced  15. Decedent's	Year or Dates:	162 Dece	dent's Usual Occupa	ation		16b. Kind of I			
215 nin 72	piet	(Specify only highest of Elementary/Secondary (0-12)	rade completed)	(Give	kind of work done of DO NOT use retired	durina most c	of working	TOD. KING OF	303111033/1110	Justry	
212 d with giene er tha	Completed	Elementary/Secondary (0-12)	College (1-4or		Director			Newspa	ıper		
Ind 21215-0036  be filed within 72 hours after death with the Maryland ital Hygiene. d other than "natural", or liema 23e or 28a-f show event, the Medical Examiner must be rediffed at	Be (	17. Father's Name (First, Middle, La.					s Name (First, Middl	e, Maiden Suma	me)		
yla nould I Men nerke	2	Charles Powell I					ie L Ruff				
Mal d 2 st th and 17 Is n traun		19a. Informant's Name/Relationship Russell Lum – DPC					or Rural Route Num. Lldersburg			Code)	
re, s 1 an l Heal Item 2		20a. Method of Disposition		20b. Place of Dispo	osition (Name of		Date	20c. Location		wn, State	
B B B S S S S S S S S S S S S S S S S S		1 ☐ Burial 2 【X Cremation 3 4 ☐ Donation 5 ☐ Other (Special			matory or other plac oln Crema:		4/12/2005	Brentw	ood,	MD	
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural; or frema 23e or 28e-1 show		21. Signature of Funeral Service Lic	ersee	1/50 12	2. Name and Addres	s of Facility	Hines-Ri	naldi Fu	neral	Home	
<b>o</b> 83 E 5 3		13. Kest	to Type	S	ilver Spr	ing, M	W_Z0904				
		23a. Part1. Enter the disease, or co shock, or heart failure. List on	mplications that cause ly one cause on each!	d the death. Do not en	ter the mode of dying	g, such as ca	ardiac or respiratory	arrest,		Approximate Interval Betw Onset and D	ween
Physician		Immediate Cause (Final disease or condition resulting in death)	_aA	spiration	Valum	mis				Dings	70atii
/Medica Examine		rosaning in dodiny	Due to (or as	a consequence of):						/	
	e e	Sequentially list conditions, if any, leading to immediate	b. Due to (or as	a consequence of):							
cuted	Examiner	if any, leading to immediate caus. Enter of Jerry 19 Cause (Disease or injury that initiated events	c								
8760, sate be executed hysician and the burial-transit	EX	resulting in death) Last	Due to (or as	a consequence of):							
	dical		d								
P.O. Box 6 that the death certific ed by the attending p	/Me	IF FEMALE:	23c. If yes, outcome	of pregnancy				224 5			
Box leath cert attending	cian	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No		2 Fetal death 3	□Ectopic pregnancy □ Other (specify)				ate of delive Ionth		'ear
P.O. nat the ded by the letached	hysi	9 Unknown	9□Unknown								
Vision of Vital Records, P.O. Box 6 Attending Physician: The law requires that the death certific releath.  ector: After this certificate has been signed by the attending pet the funeral director, page 2 should be detached for use as	by Physician/Me	Part II. Dther significant conditions	contributing to death t	out not resulting în the u	underlying cause give	en in Part I.	23e. Did	tobacco use con	ntribute to th	e cause of de	eath?
cord w require been si	ted	Demente					1	Yes 2□No	3 Prob	ably 4 🗷 U	Jnknown
Records, he law requires the has been signed age 2 should be or	Completed						24a. Wa	s an 24b	Were autop	psy findings a mpletion of ca	available ause of
Vital Fician: The certificate rector, pag							1 ☐ Yes	formed) 22 No	death? 1 🗌 Yes	2□ No	
Vital sicien: Ti certificate irector, pa	o Be	25. Was case referred to medical examiner?  1 Yes 2 No	Hospital:	2 T T D/Outsette	at 30 DOA Othe	ar.	of Death (Check only				
Division of I or Attending Phys after death. Director: After this I in by the funeral di	n: To	27. Manner of Death	28a, Date of Inju	ury 28b. Time o	III 30 DOX	4 🗀 14012	sing Home 5 ☐ Res 28d. Describe	how injury occu		"	
ion inding ath. r: Afte	Certification:	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigat	(Month, Da	ay Year) Injury		Yes 2 □ No	0				
or Attender the Directo	tific	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	28e. Place of in	jury - At home, larm, st tc. (Specify)	reet, lactory, office		281. Location City or To	(Street and Num own, State)	ber or Rura	Route Numi	ber,
Dital o								(I - TI I - I I I	ie seco		
Hospital 24 hours a Funeral (	Medical	29a. Certifier 1 ✓ Certifying (Check only one) 2 ☐ Medical Ex	Physician: To the best aminer: On the basis of and manner st	of examination and/or in	th occurred at the tim rvestigation, in my op	ne, date and pinion, death	place, and due to the occurred at the time	e cause(s) and m e, date and place	anner as st , and due to	ated. the cause(s)	)
Division of Vital Re To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Me	29b. Signature and title of certifier	1111	arod.	29c. License	number		29d. Date sign	ed (Month, I	Day, Year)	
10		<b>)</b>	/// MI)		03	3184		April	11 20	205	
- (		30. Name and address of person wh	o completed cause of	1		C. 1a	0 1 :	0 10	1	Λ. Δ	015
		Imather	Kushne	114 B	usibles (	entr	1)///	KISKS	Porn	/n1):	4136
Regis	tate trar	31. Date filed (Month, Day, Year) APR 1 4	2005 32. Fiegist	rar's Signature							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Norman Lancaster 05-2759 1- State of Maryland / Department of Health and Mental Hygiene State Of State Of Maryland / Department of Health and Mental Hygiene Certificate of Death **AKG** 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day Year 8:59 P M NORMAN LANCASTER /Medical Apri] 2005 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Holy Cross Hospital Silver Spring Montgomery If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number **Funeral** 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) 1PM 20 F 70 Director Oct. 16, 1934 217-32-4471 Maryland Usual Residence of Decedent with the Maryland 10a State 10c. City, Town or Location 10b. County or 28a-f show 10d. Inside City Limits 7 is marked other than "natural", or Itema 23a or 28a-f shov traumatic event. The Mouleal Examinat must be notified at 1 Yes 2 □ No Director MD Silver Spring Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3110 Fairland 20904 U.S.A. death Funeral Road 12. Was Decedent Ever in U.S.
Amed Forces?
1 Yes 2 No 1957 − Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 and 2 should be filed within 72 hours after theath and Mental Hygiene. Health and Mental Hygiene. Sm 27 is marked other than "natural", or Itel Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No If Yes, Give Year or Dates: Specify: Black þ 3 ☐ Widowed 4 ☑ Divorced 1962 Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Mont. County Elementary/Secondary (0-12) College (1-4or 5+) 12th Plant Operator Public Schools 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ٥ Helen Lancaster Earl Bailey 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Item 27 3110 Fairland Rd Silver Spring, Md 20904 Helen Nutter- Mother 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Pages 1 nent of H ant: If Ite cemetery, crematory or other place) 1X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or Gate of Heaven \* 4 ☐ Donation 5 ☐ Other (Specify) 4/26/2005 Silver Spring, MD Signatule of Funeral Service Licensee 22. Name and Address of Facility Snowden Funeral Home, P.A. 246 N. Washington St Rockville, MD20850 23a. Part1. Enter the disease, or complications that caused the death. Dinot enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Lung Cancer With Complications disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner hysician and the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE use a 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? ò Month Day Year 5 Other (specify) P.O. I the þ signed by be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ 1 Yes 2 No 3 Probably 4 Nunknown page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☑ Yes 2 ☐ No 24a. Was an autopsy performed? 1 Yes 2 No Hospital or Attending Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient Other: 1X Yes 2 □ No Certification: To 2XXER/Outpatient 3 □ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After 5 🗀 Pending after death. Director: A 1 TYes 2 TNo 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) hi, April 20, 2005 OCME

State Registrar

31. Date filed (Month, Day, Year)

APR 2 5 2005

LING

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

111 Penn Street Baltimore, Maryland 21201